



COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION (PEI)

PEI NOTICE NO. 2012-02
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PEI FREQUENTLY ASKED QUESTIONS

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**For Outcome-related FAQs, please refer to PEI Outcomes FAQs at
<http://dmhoma.pbworks.com/w/page/40360716/PEI%20Outcomes%20FAQ> or
contact PEIOutcomes@dmh.lacounty.gov**

GENERAL

1. Who is appropriate for PEI Services?

According to the Prevention and Early Intervention Plan for Los Angeles County (August 2009), PEI focuses on evidence-based, promising or community defined evidence practices, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Specifically, early intervention services are directed toward individuals and families for whom a short-term (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health situation early in its manifestation. Early intervention services may avoid the need for more extensive mental health treatment, or prevent the mental health problem from becoming worse.

2. How do we handle clients who drop out in the middle of treatment and return to the program later on?

In general, this situation would be handled in the same way as clients receiving basic mental health services. EBPs focus on outreach and engaging client's and families' participation in services and completing treatment, therefore the clinician would outreach to the client/family before closing the case. If the client does not return, the case would close and documentation would include reason(s) for termination and the data gathered from the outcome measures would be recorded. If the client returns within the year an assessment addendum or full assessment would be completed with strong justification for allowing the client to initiate treatment again. The decision for returning would also be based on the Provider's expertise, consultation with the EBP/Promising Practice consultant if available, and other subjective clinical factors that would need to be looked at on a case-by-case basis.

3. Who monitors when sessions are completed?

It is the responsibility of the agency to monitor completion of treatment and to ensure that all documentation is complete.

4. Is there an authorization process if a Provider needs to repeat treatment for the same client?

There is no authorization process. Each Provider is trained on which clients are appropriate to receive EBPs. Generally, it is not recommended that clients repeat treatment after completing an EBP; however, there may be circumstances in which it would be clinically appropriate to review the client's and family's needs. This would be on a case-by-case basis with strong justification for repeating treatment as required for ongoing utilization monitoring.

5. Who monitors the monthly reports?

Agencies are always responsible for remaining aware of their service delivery patterns and adjusting service delivery as necessary to remain within their contractual requirements. DMH will be developing reports to help agencies with

this process. It is anticipated that Lead District Chief staff and/or Service Area District Chief staff will also have a role in monitoring monthly reports.

6. Who monitors the agency's compliance with completion of outcome measures?

Monitoring outcomes is a joint agency and DMH responsibility. By agencies monitoring their own outcomes, clinicians can receive useful information regarding service delivery.

7. Who is responsible for the analysis of the data collected?

Data is provided to DMH PEI OMA and CIMH. Please refer to your PEI Outcomes Table for information on which EBPs go to DMH vs. CIMH. DMH and CIMH will analyze data, create reports.

8. What will be the responsibility of Service Area staff?

Lead District Chief and/or Service Area staff will assist with monitoring PEI programs and other duties as the program unfolds.

9. Who is responsible for keeping track of who is certified in each EBP?

Agencies and DMH will be keeping track of who is certified.

10. Can we complete another assessment when a client changes from one EBP/intervention to another EBP/intervention?*

EBPs are intervention strategies. Changing intervention strategies/EBPs is not sufficient reason, in and of itself, to complete another assessment. For further information please refer to the Assessment sections, pages 2-3 and 2-7 through 2-8, of the Short-Doyle/Medi-Cal Organizational Provider's Manual (hereafter Provider Manual).

11. When would I complete an assessment addendum?*

An assessment addendum can be completed when an existing assessment does not accurately reflect the client's current status. A child short format assessment may also be completed in this type of situation. In addition, an assessment addendum can be completed when there is additional pertinent or valuable assessment information received or discovered after the assessment period (the assessment period is 60 days from the date of admission).

12. How does our agency start providing mental health services in schools?*

You can contact your Service Area District Chief for the name of the Service Area School-based Coordinator. The School-based Coordinator will guide you on the process of providing mental health services in the schools.

CLAIMING

1. Can Medication Support Services be claimed under the PEI Plan?

Yes, Medication Support Services may be claimed as a non-core service for a specific PEI Program while an individual is receiving mental health services under a PEI Program.

2. Will there be any changes in documentation requirements for PEI EBPs?

No, all payer source documentation requirements remain the same (adhere to DMH Policy 104.8 and the Organizational Provider's Manual). The EBP developer may have documentation requirements which must be followed but cannot take precedence over documentation requirements of the client's payer source.

3. If a Provider enrolls a client who has another payer source (such as Medi-Cal or EPSDT); do they claim MHSA funds or the payer source?

Upon enrollment, all PEI clients should undergo a standard financial screening to determine their eligibility for benefits and ability to pay for services (UMDAP). Agencies are to assist their clients in establishing any benefits they are eligible for. All other payer sources, e.g., Medi-Cal, Medicare; Healthy Families; AB 3632; etc., should be claimed for eligible services before claiming MHSA funds. The client's funding sources can include private insurance, public programs, and the family's ability to pay. Keep in mind that almost all funding sources will claim to a client's payer source first. For example, if a client has Medi-Cal and you choose a PEI plan, Medi-Cal will be claimed automatically as long as the Medi-Cal box is marked and the match will come from the funding source (in this case, the PEI plan). Medi-Cal should be claimed if all requirements for Medi-Cal claiming are met (i.e. Medical Necessity criteria are met, service is reimbursable).

4. How do we claim for a child in FSP and an EBP?

The EBP will be claimed under FSP Plan since FSP is an all-inclusive service.

5. How do we claim for a child in Wraparound and an EBP?

If the Wraparound Provider delivers the EBP, then the Provider will claim to the appropriate Wraparound Plan. If the child is linked to another Provider to deliver the EBP, then the other Provider will claim the appropriate plan, which may be a PEI Plan. PEI Outcome measures are required when claiming services to a PEI Plan.

6. How do we claim for a child in FCCS and an EBP?

FCCS services are claimed to the FCCS Plan and the EBP is claimed to the PEI Plan. PEI Outcomes measures are required.

7. How do Providers use the IS system to claim against the new PEI plans?

In the Outpatient Claim – Plans screen, Provider selects the age-appropriate PEI Plan. The available plans are listed below:

New PEI Plans		Effective on services date
2091	PEI_Special_Progra	7/1/2010
2098	PEI_Children	5/11/2010
2101	PEI_TAY	5/11/2010
2092	PEI_Adult	7/1/2010
2093	PEI_Older_Adult	7/1/2010

8. How would we choose the procedure code in the IS for a group where both children and TAY are present?

No group procedure codes are specific to the ages of the clients present. The Plan is chosen for each individual client in the group (for agencies using the LAC-DMH group log, the plan is listed for each client on the group log). For the children in the group you would choose the Child PEI plan and for the TAY age clients in the group you would choose the TAY PEI plan.

9. Will Providers be able to claim to COS?

No, COS funding is not included in the PEI Plans.

10. If a child who was opened under a PEI Plan no longer receives mental health services (such as rehab services) but continues to receive medication support with the psychiatrist, can the psychiatrist continue to claim under PEI?

No. The Provider must use another funding source (not a PEI Plan).

11. When a client is seen for an EBP and then has a session that has nothing to do with the treatment of the child, are both sessions claimed as the EBP? Or is the funding source split? For example, we are seeing a child and a mother under TF-CBT and are doing trauma work. Then there is a separate session due to issues in the mother's marriage, how would we claim for both of these?

If the session has “nothing to do with the treatment” then it is not a claimable service to any funding source and would be documented on a separate Progress Note with no procedure code. If the session does in fact relate to the treatment of the client (i.e. the mother's marital issues are impacting the client's mental health and the focus is on this impact and how she can minimize it for the client), and fits into the TF-CBT model, then you would write a separate Progress Note with a collateral procedure code and claim it to the PEI Plan.

12. Is psychological testing covered under PEI?

Providers who want to provide psychological testing will need to ask their Lead District Chief to process the PFAR in order to add psychological testing to their PEI Plan.

13. If we are currently offering other EBPs can we claim those to PEI?

In order to claim to PEI, EBPs need to have been approved by the Service Area District Chief and included in your contract with DMH. In order to add/drop an EBP, please complete the PEI Program Add/Drop form.

14. When selecting EBP codes for core services in the IS, why/when would we use the Service Strategy codes?*

You would select Service Strategies along with an EBP when you want to reflect a broader description of the services you are providing that are not fully captured in the EBP. If your opinion is that the Service Strategies are already reflected as part of the EBP, then there is no need to report the same components of the service as Service Strategies.

15. Our EDI provider informed us that the PEI plans for children only apply to children ages 0-15. We are currently seeing children between the ages of 0-17. Is there another plan that we can use to claim these services or can we only provide EBP/PEI services for children 0-15? What if we do not have funding for TAY?*

For PEI services, the plan you claim corresponds to the age the client is at the time of the service. If the client is 15 as of the time of the service, you would select the PEI Children IS Plan. If the client is 16 years old at the time of the service, you select PEI TAY IS plan. Contractors that transformed to either PEI Child or PEI TAY programs were given both IS plans for claiming. Please check with your lead district chief about the allocation of your PEI dollars into the PEI subprograms in your negotiation package and whether any revision is necessary.

16. Can Report Writing – No contact (90889) and Review of Records (90885) be claimed to a PEI Plan?

Yes, if these are already in your contract and your agency wishes to use PEI funding for this purpose.

ENROLLMENT

- 1. Does PEI require a referral and authorization process through the Service Area Impact team that is similar to FSP clients?**

No, PEI does not have a centralized referral authorization process. Each PEI Provider determines internally how referrals are generated.
- 2. If a client is transferred within the same Legal Entity between programs that have the same Provider number (i.e. EBP and Outpatient have the same Provider number), does a new episode need to be opened and new Assessment/CCCPs completed?**

No, if the EBP will be provided within the existing Provider number, no new episodes, assessments or CCCPs need to be completed. However, you must ensure that the goals/objectives on the CCCP continue to be appropriate and cover the types of services provided under the EBP.
- 3. If a client is transferred within the same legal entity from an outpatient program to a PEI program that have DIFFERENT Provider numbers, does a new episode need to be opened with new Assessment/CCCPs completed?**

If the client is transferred to a program with a different Provider number, then a new episode must be opened. The new episode is opened at the point in which the client presents at the new program. The new Provider needs to determine if the existing Assessment accurately reflects the status of the client. If so, it is acceptable for a copy of the Assessment to be placed in the new record and used. If not, the new Provider may do a new assessment, child short format assessment, or assessment addendum, depending upon the need. A copy of the existing CCCP may be placed in the new record and used as long as the goals/objectives are appropriate to the EBP. (Quality Assurance Bulletin No. 08-2; July 14, 2008)
- 4. Can a child in FSP be receiving EBP interventions?**

Yes provided the EBP is clinically appropriate (for clients symptoms and not overwhelming for the client/family/caregiver) and that there is no duplication of services
- 5. Can a child in Wraparound be receiving EBP interventions?**

Yes provided the EBP is clinically appropriate (for clients symptoms and not overwhelming for the client/family/caregiver) and that there is no duplication of services
- 6. Can a child in FCCS be receiving EBP interventions?**

Yes provided the EBP is clinically appropriate (for clients symptoms and not overwhelming for the client/family/caregiver) and that there is no duplication of services.

7. Can a child be receiving two EBPs at the same time?

This should be the exception rather than rule as the recommendation is to implement 1 EBP at a time. The clinician should identify along with the client/family, the primary issues and identify the best fitting service. Upon completing that service (EBP), if necessary, the client could start another EBP to address remaining issues. Other considerations in implementing more than 1 EBP include clinical appropriateness, duplication of services, overwhelming the client/family, and what outcomes are required for each EBP.

8. If a potential client for an EBP also has a co-occurring diagnosis of Pervasive Developmental Delay or also has developmental delay issues, can the individual still receive the EBP?

The answer depends on what is clinically appropriate given an assessment of the client's presenting problems, functional impairment; and ability to benefit from the chosen EBP.

9. Our agency will be serving Healthy Families clients. How do we check eligibility?

This will be covered in the Healthy Families training that all new Healthy Families Providers receive from the Healthy Families Unit.

AGGRESSION REPLACEMENT TRAINING (ART)

1. What are the components of ART®?

The components of ART® are based on social learning and cognitive behavior theories:

1. Skillstreaming

- The behavioral component
- *Teaches what to do*

2. Anger Control Training

- The emotional component
- *Teaches how to recognize and control anger*

3. Moral Reasoning Training

- The cognitive component
- *Teaches why to use pro-social skills*

2. What is the age range for ART®?

ART® (all 3 components) is for clients ages 12-17. Clients who are ages 5-12 are to be provided with **only** the Skillstreaming component of ART®.

3. What is the focus of treatment for ART®?

The focus of treatment for ART® includes children and youth with disruptive behavior disorders who are at risk of or involved with the juvenile justice system.

4. What is the treatment modality?

The treatment modality for ART® is group format. Individual sessions may be used to make up missed group sessions.

5. What are the minimum and maximum clients allowed per group?

The developer recommends 8 to 10 participants per group; not to exceed 12.

6. How many group facilitators are needed?

Model adherent ART® groups are conducted by 2 facilitators (co-facilitators).

7. How often should ART® sessions be conducted?

Model adherent ART® sessions are conducted in 3 group sessions (using each of the 3 components: Skillstreaming, Anger Control and Moral Reasoning) per week. When providing the Skillstreaming component of ART® only, for clients ages 5-12, sessions (in Skillstreaming only) are conducted 1 time per week.

8. What is the length of treatment?

The length of treatment for model adherent ART® is 10 weeks. When providing the Skillstreaming component of ART® only, for clients age 5-12, the length of treatment is also 10 weeks.

9. What are the “Core Interventions” for ART®?

The “Core Interventions” include:

- i. Assessment
- ii. Collateral
- iii. Group Psychotherapy
- iv. Group Rehabilitation
- v. Individual Psychotherapy (to “make up” a missed group session)
- vi. Individual Rehabilitation Service (to “make up” a missed group session)

10. Do you have to be a licensed clinician to implement ART® under the PEI Plan?

No. Please see Question #11. Please see current version of the County of Los Angeles – DMH, “A Guide to Procedure Codes” for specific Rendering Provider eligibility.

11. What is the minimum amount of education required to be trained in and apply this evidenced based treatment, in order to stay within an appropriate “scope of practice?”

The services listed under Core Interventions for each evidenced based treatment will determine the rendering provider’s scope of practice. For example, if one of the core services is Assessment, an AMHD must complete the Assessment. If the core service is Individual Rehabilitation (Rehab), anyone within their scope of practice can provide Rehab services.

As it relates to non-licensed staff (Medical Case Worker, Substance Abuse Counselor, and Community Worker) providing individual/group rehabilitation will be based on the supervisor’s discretion. This means that the supervisor has assessed the staff’s knowledge, experience, and reviewed staff’s documentation and decided that the staff is capable of providing and documenting Rehab services (with or without co-signature).

12. Is there a “train the trainer” model for ART®?

Yes. The “train the trainer” model for ART® includes:

- i. Completion of the ART® training protocol
- ii. Co-facilitate a minimum of 72 groups within a 12-month period, with at least 12 groups in each component
- iii. Rating of competency on each item of the Trainer Competency Rating Scale on at least one submitted videotaped session that occurred within 12 months
- iv. 2-day Agency Trainer training
- v. Participation in 15 consultation calls
- vi. Conduct and complete ART required training protocol with 2-6 trainees
- vii. Videotaped submission of excerpts of conducted trainings
- viii. Demonstration of trainer proficiency by videotape review of trainees

13. What are the required Outcome Questionnaires for ART®?

DMH PEI Outcome Measures Application Requirements: The outcome measures should be administered pre- and post-treatment. Additionally, if the ART® treatment extends beyond 6 months, an update for each measure is required every 6 months. The required outcome measures are the following:

- Youth Outcome Questionnaire (YOQ)
- Youth Outcome Questionnaire-Self Report (YOQ-SR)
- Eyberg Student Behavior Inventory (ECBI) or Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R), if parent is unavailable to complete the ECBI

Note: Even though the SESBI-R is required only when the ECBI cannot be obtained, both the ECBI and SESBI-R must be acknowledged in the PEI OMA. This is achieved by entering either the scores or an 'Unable to Collect Reason Code' for each measure.

CiMH/Developer Requirement: The SkillStreaming Checklist is required to be administered pre and post Social Skills Training component of ART®. The developer highly recommends the Aggression and How I Think Questionnaires to be administered pre and post the Anger Control Training and Training in Moral Reasoning components of ART®, respectively.

14. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs, YOQ-SR)?

Administration can be completed by a trained non-clinical or clinical staff. Scoring and interpretation can be completed by a person enrolled in a graduate degree program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waived staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

15. What staff qualifications are required to administer, score/interpret, and input data for the ECBI and SESBI-R?

Administration can be completed by a trained professional with a minimum of a bachelor's degree in psychology or related field. Scoring and interpretation can be completed by a person enrolled in a graduate degree program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waived staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)

- 1. Can the principal or principal designee participate in place of the teacher?**
Although principals and other administrators can participate in teacher in-service education on trauma, it is not recommended that they take the place of the teacher. Teachers are the primary point of contact for students and have much to benefit from understanding the many problems that can result from traumatic experiences.
- 2. Are the two-parent education sessions held in group format or are they with each parent and a participating child?**
It is up to the Provider. However, individual sessions with parents appear to be the best way to involve them.
- 3. Is the Provider responsible for communicating and making arrangements for space (rooms) with the schools?**
Yes. All experienced school-based mental health service Providers are well aware of how to negotiate with schools for space. Space is at a premium in most inner city schools. Some school-based clinicians do individual therapy in creative “found” space. CBITS presents a particular challenge because a school may not have the space to allocate for a group once a week for ten weeks.
- 4. What is the role of the DMH school-based coordinator?**
This role may differ from Service Area to Service Area based on the unique needs of the population being served. Please consult with your service area lead District Chief or contract lead to discuss the role that your specific DMH school-based coordinator will play.
- 5. Is there a limit to repeating the group?**
Many youth screened for CBITS have experienced multiple traumas. It is recommended that the youth and therapist select one trauma that can be worked on successfully. Other traumas may require other forms of treatment. It is hoped that the lessons learned in CBITS would generalize to other traumatic events. Repeating CBITS for any child should be discussed with Provider Supervisors/Managers and possibly with Service Area Program Administrative staff persons. The CBITS Child PEI Team lead can also be consulted.
- 6. Can CBITS be delivered in a setting other than a school site?***
Yes, however it is the provider’s responsibility to ensure that even if CBITS is NOT being delivered in a school site that there be clear documentation in the clinical record of ongoing coordination/communication/linkage by provider staff with school personnel regarding the client/family being served.

7. Since high drop-out rates occur in groups, can one therapist conduct the CBITS group if it dropped to five students?*

There is no absolute prohibition against one therapist running a group alone, although it is felt this might be taxing for that therapist. The problem is not solely the group count. It is important to remember that for this EBP each participant receives group therapy as well as 3 individual sessions, 1-2 collateral sessions and teacher education. The individual sessions occur in the early stages of the treatment targeting exposure before the group sessions, and the collateral sessions occur toward the end of the treatment.

CHILD-PARENT PSYCHOTHERAPY (CPP)

- 1. What is the age range for the CPP model (what ages are included)?**
Clients starting treatment can range from 0 months to 5 years, 11 months. Treatment must begin on or before the 6th birthday. Once in treatment, CPP is validated for children ages 0 to 6 years.
- 2. Must my client have experienced trauma to qualify for CPP?**
Yes, for the purposes of claiming to the DMH PEI Child Plan the child must have experienced trauma. You may use CPP to serve other populations with a different funding source.
- 3. How is “trauma” defined for babies/toddlers and what do I look for as far as symptoms in this young population?**
This is a clinical question. If your agency is new to working with this age group, the developers and DMH recommend starting with older children and seeking experience through consultation, trainings, and observations (e.g., child care setting, family members, friends) to build up your scope of practice. You might also try connecting/consulting with agencies experienced in Birth to Five. Also see *Scope of Practice* (below).
- 4. Must my client have a diagnosis of PTSD for the CPP model?**
No, PTSD does not have to be the diagnosis in order to use the CPP model, but please use your clinical judgment to decide if CPP is an appropriate model for your client. As is always the case, in order to claim to Medi-Cal, your client must meet criteria for a Medi-Cal eligible diagnosis and the service provided must be claimable to Medi-Cal.
- 5. What are the outcome measures for CPP?**
The outcomes are YOQ-Parent Report (ages 4+) and Trauma Symptom Checklist for Young Children (ages 3+).
- 6. What outcomes do I collect if my client is too young for the outcome measures?**
In these situations you would open a Treatment Cycle in PEI OMA and provide the required client information at pre, update, and post treatment. PEI OMA will recognize instances when an outcome measure(s) score(s) is not entered due to a client's age being below minimum age requirement and will not create space for entering the outcome measure's score(s).
- 7. What are the screening measures for CPP?**
The CPP model strongly encourages screening for trauma prior to beginning treatment. Your agency is at liberty to select the screening tools of your choice. The developers recommend *The Life Stressor Checklist-Revised* (which screens for the caregivers trauma) and the *Traumatic Events Screening Inventory – Parent Report Revised* (parent report of the child's trauma). Both of these

measures are free, were distributed at the CPP training, and are available on the CPP google docs for trainees.

8. **The CPP model requires talking with the caregiver about the child's trauma and the caregiver's trauma. To do this, we have to meet with the caregiver alone prior to meeting with the child. Can we open the case without seeing the child?**

No, you cannot open the case prior to seeing the client.

9. **If I cannot open the case, can I claim for service prior to opening the case?**
Yes, you can have a collateral session prior to having face-to-face contact with the client; HOWEVER, you must have face-to-face contact with the client within the same calendar month. Please refer to *Bulletin 09-07 Opening Date for Case Episodes* dated November 13, 2009 for guidelines.

10. **As part of the CPP training, we need to complete process/narrative notes. Can we claim for that time?**

No, the process/narrative note is not a service to the client; it cannot be claimed to Medi-Cal as a service to the client. The intention of the process/narrative note is to benefit the clinician's learning.

11. **Who can supervise a clinician going through the CPP training?**

While the clinician is participating in the CPP training, the clinician is supervised by a CPP supervisor who meets the requirements to act as a CPP Supervisor (see below) and has authority over the clinician's CPP cases.

12. **What are the requirements to act as a CPP Supervisor for a CPP trainee?**

1. The CPP Supervisor must attend the initial CPP Supervision training.
2. The CPP Supervisor must have completed the year and a half CPP training OR currently be participating in the CPP training, which includes carrying a case, participating in consultation calls, and attending booster sessions. In addition
3. The CPP supervisor meets the requirements to supervise set forth by their respective licensing board (ie, CA Board of Psychology, Board of Behavioral Sciences). Thus, the supervisor is operating within their scope of practice.

13. **What kinds of trainings/resources might we seek out to build our clinicians' capacity to serve children ages 0-5?**

The state of California has developed guidelines and is in the process of developing a Birth to Five certification for professionals serving children ages 0-5. The guidelines can be found at <http://wested.org/cpei/forms/training-guidelines.pdf>

Locally, you may also join the Los Angeles Infancy, Childhood, and Relationship Enrichment (ICARE) Network by e-mailing rcurtis@dmh.lacounty.gov. The

ICARE Network hosts monthly meetings and sends e-mails about trainings in 0-5.

In addition, each Service Area has a 0-5 Collaborative meeting and a DMH Birth to Five Coordinator who hosts those meetings. You may contact your lead district chief to find out who the DMH Birth to Five Coordinator is in your Service Area. Finally, as stated above, seeking consultation and observing children in various settings is also recommended as well as working collaboratively with agencies well versed in 0-5.

14. What kinds of trainings might we seek out to build our clinicians knowledge of trauma?

The National Child Traumatic Stress Network <http://www.nctsnet.org/> has many resources available including articles, screening tools, etc. In addition, they offer free online courses with CEs.

CRISIS ORIENTED RECOVERY SERVICES (CORS)

1. What is the goal of CORS?

To provide immediate crisis intervention and increase adaptive coping strategies which the individual can utilize to manage stress and return to their previous or higher level of functioning. Specifically, CORS is designed for individuals who have experienced a recent event that has disrupted the person's usual equilibrium and created a vulnerable state.

2. Which model is CORS based on?

CORS is Promising Practice based on the model developed at Didi Hirsch Community Mental Health's Benjamin Rush Center for short-term (up to six calendar weeks) crisis intervention. Its' origins are based on principles found in psychoanalysis, sociology, and life stress research. Any client receiving services in DMH who may have experienced a recent trauma, crisis or "hazardous event" may benefit from CORS.

3. For whom is CORS appropriate?

CORS is designed to serve Transition Age Youth (TAY), Adults, and Older Adults (OA) who have experienced a hazardous event within the previous three months. For Children, the model allows for a longer timeline between the experience of a hazardous event and the request for help, up to 6 months.

Identifying clients for CORS and supporting them during the psychotherapy component is critical to the successful implementation of this Practice. Distinguishing those symptoms that might be caused by the "hazardous event" from other symptoms that may be long-standing, can be accomplished by a skilled diagnostician, and, when indicated, with the assistance of a psychiatric evaluation.

The clinician completing the assessment can also initiate additional supportive interventions when necessary to permit CORS to be an effective practice. A client in crisis caused by a hazard may suffer from additional symptoms unrelated to the crisis. Such clients require further evaluation or intervention not typically offered during the course of CORS. For example, a client in crisis may also suffer from a previously stabilized Bipolar Disorder. The client may be a good candidate for the crisis treatment but also benefit from medication treatment for the Bipolar disorder.

CORS is a Practice effective for clients presenting with Dysthymia, Anxiety disorders, and Adjustment disorders. However, other diagnoses, such as Acute Stress Disorder, Depressive Disorder NOS, PTSD, and even Major Depression are common and have been successfully treated with CORS. It is the presence of a stressful event and an inability to cope with the event that defines good candidates for this practice.

4. When is CORS contraindicated?

The model is not suited for individuals who are in a chronic state of crisis, or who are persistently mentally ill and not able to identify a specific crisis. This Practice may be more effective for clients who voluntarily seek treatment, rather than those who are involuntarily participants.

5. What is considered a “hazardous event”?

An external life event that disrupts a person’s usual functional equilibrium and creates a vulnerable state; the event occurs within three (3) months of the initial call or visit to the clinic for TAY, Adult, and Older Adults and within six (6) months for Children.

A hazardous event is defined as an external stressor that is new to the individual(s) and has overwhelmed his/her previously successful coping strategies.

The external event signifies a loss or threat of loss, creating disequilibrium in a steady state. The possible losses include the loss of self-esteem, loss of role mastery, loss of nurturance, or loss of physical integrity (safety).

6. What is the definition of a “crisis” in this Practice?

A crisis is defined as “a state provoked when a person faces an obstacle (hazard) to important life goals that is temporarily insurmountable through customary coping behaviors. A period of disorganization follows during which many attempts at solution are made. Eventually, some kind of adaptation is achieved which may be adaptive or maladaptive”.

7. What are the key questions for clinicians in this Practice?

Based on the developer’s guidelines, clinicians should determine and document the following: “Why now?”, “How long has the hazardous event been going on?”, “What is different this time which motivated the client to contact them?”, “What coping mechanisms were used previously that are not now working?” “Who was the last contact for the person prior to asking for help?”

One of the key points in CORS is to describe to the client and document the “meaning attached to the crisis” for the person or family. The meaning always involves a loss or threat of loss.

8. Does the clinician have to cover all three (3) phases of CORS?

Yes. The developer requires the clinician complete all three phrases:

- 1) Assessment Phase: (Session 1) The clinician assesses the client, develops a timeline of events, explores the meaning of the hazardous event, assesses for homicidal/suicidal ideation, and develops a reformulation of the crisis; including a cognitive understanding of the loss or losses involved.

- 2) **Treatment Phase: (Sessions 2-5)** In the treatment phase, the clinician assists the client to develop an affective understanding of the problem and establish new coping skills (Session 2-5). The clinician helps the client become aware of feelings regarding their loss or feared loss, which s/he may not have accessed during the crisis. The clinician works with the client to recognize maladaptive coping behaviors and develop adaptive coping strategies to manage the crisis. The work involves both insight on the part of the client regarding their feelings and associated responses, and behavioral change.
- 3) **Termination Phase: (Session 6)** The clinician summarizes the crisis, discusses possible future hazards and engages in anticipatory planning should another crisis arise, and addresses feelings related to termination. Evaluation for ongoing treatment in a different modality would also be done at this phase, however the department expects that many if not most cases will be closed.

9. What type of treatment is generally offered through CORS?

CORS consists of weekly individual therapy sessions for TAY, Adult, and OA and weekly family therapy sessions for Child.

10. According to the developer, individual sessions can either be 60 or 90 minutes long. What is the Department's requirement?

There is no Department mandate limiting the time frame of individual sessions. Clinicians can provide a 60-minute or 90-minute session on a weekly basis.

11. What are the core interventions for CORS?

The core interventions for CORS are:

- 1) Assessment (Procedure Code 90801 and 90802)
- 2) Individual Psychotherapy (Procedure Code H0046, 90804, 90806, 90808)
- 3) Family Psychotherapy (Procedure Code 90847) (for children only)
- 4) Group Psychotherapy (Procedure Code 90853) (for community at large only)

The use of Group Psychotherapy might be suitable for group members that have each experienced the same "hazardous event"; for example, a hurricane, fire, or other natural disaster. However, Group Psychotherapy is not usually indicated with this model as it applies primarily to people with individual hazards that have a particular meaning to them.

Other interventions, which may be appropriate for clients receiving CORS during the allowable six weeks course of treatment, may include:

- 1) Collateral (Procedure Code 90887)
- 2) Targeted Case Management (Procedure Code T1017)
- 3) Medication-related services

The use of targeted case management may be appropriate if providing these services will reduce the effects of the hazardous event, i.e. the client is unexpectedly homeless or unemployed, and needs to be linked to services.

12. Who can provide CORS?

CORS must be delivered by a trained psychotherapist. Staff that may provide CORS include: licensed, registered, or waived MD/DO, Ph.D/Psy.D., LCSW, MFT, NP/CNS, RN, and student professionals in these disciplines with a co-signature.

13. Does the Department require a clinician to maintain a certain number of CORS clients on their caseload?

No.

14. What role can paraprofessionals play with this Practice?

The primary clinician can work with paraprofessional staff to ensure the client is provided linkage, case management, and care coordination.

15. What role may a psychiatrist play within this Practice, and how are associated psychiatric services claimed?

As part of the comprehensive assessment, the clinician may decide to refer the client for a psychiatric evaluation. For instance, a client presenting with symptoms of anhedonia, sleeplessness, loss of appetite, psychomotor retardation, and suicidal rumination, perhaps caused by a hazard, may respond well and quickly by the supplementation with psychotropic medication to the CORS practice.

If the CORS treatment team determines medication support is necessary, medication support can be provided in conjunction with the CORS therapy sessions. The clinician and psychiatrist can determine if continuing the medication support beyond the completion of six weeks of CORS psychotherapy is clinically indicated. The clinician and psychiatrist will complete or change the Client Care Coordination Plan (CCCP), documenting which level of service best addresses the consumer's continuing mental health needs. Directly Operated Clinics should refer to the memo from Dr. Marvin Southard dated 1/25/12 for more information on providing extended medication support to their PEI client receiving CORS services.

16. What is the length of treatment for CORS?

The treatment of CORS is limited to a maximum of six (6) calendar weeks. CORS is intended to address a crisis situation rather than an ongoing illness. **A crisis is considered a time-limited event. Some crisis situations may resolve in a shorter period of time.**

17. Can CORS ever be extended past six weeks?

Yes. According to the developer, the treating clinician can make the clinical decision to extend the Practice for TWO weeks (i.e., 8 weeks total treatment duration) if the client experiences a second, genuinely new crisis during the course of treatment.

Another reason for possibly extending the duration of treatment would be if the client expresses suicidal thoughts. In this case, the Practice may be extended to stabilize the client and link the client to needed, ongoing mental health treatment and services.

18. What should the clinician do if the client misses two or more sessions?

Since CORS is time-limited to six calendar weeks, the developer does not recommend continuing CORS if the client misses two or more weeks. If the client misses one week of treatment, the clinician may complete two sessions in one week to make up for the missed week; however, the total time of treatment should not exceed 6 calendar weeks.

19. Is the initial assessment visit always claimed to CORS?

No. However, the Department has established claiming guidelines for the Directly Operated Adult clinics, wherein the clinician completing the initial or short assessment will claim this service to the PEI Adult billing plan (PEI Adult: Ages 26-59, Plan No. 2092).

Across all age groups, services claimed to a PEI billing plan must have a PEI-approved EBP code selected in the IS. The clinician will select the appropriate EBP code on the drop-down menu once s/he determines which EBP/PP/CDE best addresses the client's needs. For example, if at the initial assessment the clinician concludes the client is appropriate for CORS; s/he will select the corresponding code for "PEI CORS" (4D) in the IS. Directly Operated Clinics should refer to the memo from Dr. Marvin Southard dated 1/25/12 for more information on when it is appropriate to use other EBP codes beside 4D during the assessment period.

If at the initial visit the clinician determines the client does not meet the PEI target population and, instead, refers the client to one of the MHSA CSS or non-MHSA programs, s/he will claim the services to the appropriate IS billing plan. No corresponding EBP code will need to be selected.

- 20. Does the week which includes the initial intake session count toward the six week limit?**
No. The week when the clinician completes the initial intake session is not included in the six allowable weeks of this Practice.
- 21. Can clinicians use the Short Assessment form for new clients?**
The Short Assessment Form can be used; however completing the full Adult/Child Initial Assessment is considered best practice. An Assessment Addendum must be completed (NOT a full assessment) if the client continues to receive mental health services beyond 60 days.
- 22. Does the primary clinician need to complete the Client Care Coordination Plan (CCCP) when administering this Practice?**
No, because the CORS treatment is only six (6) weeks; treatment ends within 59 days of opening the case. Should the treatment extend to or beyond 60 days, the CCCP will need to be completed and expected treatment outcomes defined. For existing clients open in another modality, CORS should be added to the CCCP plan that is already in the chart. If a client comes to a new provider requesting CORS, but has an open episode with another provider, the new provider will contact the existing provider to be added to the CCCP within 30 days, as per County protocol.
- 23. Can a client from one of the non-MHSA or MHSA Client Supportive Services (CSS) plans (Wellness, Field Capable Clinical Services, or Full Service Partnership) receive this Practice?**
Yes. Any client for whom CORS practice is clinically indicated, can receive this CORS treatment. This is true of other PEI practices as well. The service is claimed to the MHSA plan/Level of Care in which the client receives their primary services—and NOT to PEI. For example, a CSS Wellness client can participate in CORS if the client experienced a hazardous event in the previous three (3) months which caused a crisis affecting their previous equilibrium. However, the client will continue to be billed under the "MHSA_Fam_Focused_Wellness Svc" billing plan, not under the "PEI Adult: Ages 26-59, Plan No. 2092". The clinician will identify the EBP as "PEI-CORS" (4D), but no outcome measures are required when the EBP is administered to a client enrolled in a different plan (i.e., not PEI).
- 24. What happens if the client successfully completes CORS?**
- 25.** The client will be discharged and their case will be appropriately closed. They may return, if needed, should they benefit from another course of CORS or alternative interventions in response to a subsequent crisis.
- 26. What happens if the client continues to experience disruption in their level of functioning?**
The treating clinician should consider the following questions:

- 1) Why is the client's maladaptive response to the hazardous event still lingering? Has he/she not found an adequate alternative coping mechanism? Do we need to pull in some supportive persons in the client's life to assist?
- 2) Have we appropriately identified the hazard and the meaning of the hazard for the client, so they can understand their situation and find an alternative coping response?
- 3) Is the person experiencing unresolved grief that is now chronic?
- 4) Was CORS the most appropriate treatment to provide to this client based on the situation? If not, is there an intervention which would address the client's needs more effectively?

The treating clinician can link the client to continued care, via another non-MHSA or MHSA CSS level of service, such as FCCS or Wellness.

Some clients may be appropriately served in another PEI EBP for continued care.

27. When should the clinician discuss the possibility of on-going treatment with the client?

The developer recommends discussing referrals for on-going treatment during the 5th or 6th weekly session.

28. Can a client receive CORS along with another PEI EBP?

The goal of CORS is to help the client move forward quickly in coping with a crisis; using a brief and focused intervention and their own resources. Therefore, the Department expects that the use of multiple practices for PEI clients is occurring infrequently.

29. What is the required training protocol?

The CORS training protocol consists of a one-day, six-hour training, or split over two half-days. Some CORS trainers may provide additional on-site consultation support as needed to fully integrate the model into Practice.

30. Is there a certification process?

No. However, the model should only be practiced by clinicians who have received the full 6 hours of training in CORS.

31. Is "train the trainer" available for CORS?

Not at this time.

32. Does CORS require a CORS-trained supervisor as part of the practice?

A specific supervisor training in CORS is not available at this time. The Department does require a licensed supervisor to be available to assist the CORS clinician as needed. At a minimum, the department requires this

supervisor be trained in the CORS model, and where possible, participate in an ongoing consultation group provided by DMH.

33. What outcome measure should be used with this Practice?

Clinicians will administer the Youth Outcome Questionnaire (YOQ) to parents of youth (ages 4-17) and Youth Outcome Questionnaire-Self report (YOQ-SR) for Children and younger TAY (ages 12-18).

Clinicians will administer the Outcome Questionnaire (OQ) (ages 19+) for older TAY, Adults, and Older Adults.

There is no treatment specific outcome measure for this Practice for children under the age of 18, TAY, Adults, or Older Adults at this time.

34. When should the outcome measure be completed?

Outcome measures are to be completed 14 days from the date of the First EBP Treatment Session to collect the “Pre” measures, and 14 days from the date of the Last EBP Treatment Session to collect the “Post” outcome measures. PEI outcome measures should also be administered at the 6 month mark (an “Update”) to clients enrolled in an EBP that lasts 6 months or longer.

35. Can the clinician claim for administering the outcome measure?

No.

FAMILIES OVERCOMING UNDER STRESS (FOCUS)

1. What is Families Overcoming Under Stress (FOCUS)?

FOCUS is a promising practice (PP), which is a family-centered, resiliency training program designed to bridge communication and support in families contending with trauma, stress or loss. Initial implementation at the Department of Mental Health's (DMH) Directly Operated programs was dedicated to assisting service members and their families in successfully navigating through the stressors and troubles associated with military deployment(s). However, it has subsequently been adapted to provide resiliency training to civilian families who have suffered from the effects of traumatic events.

FOCUS teaches families core skills that will better equip them to deal with stresses and changes associated with wartime deployment, injury, illness, death and a range of other traumatic experiences. FOCUS assists families on increasing communication and family cohesiveness. By expressing and exploring different family members' perspectives of a traumatic event, the family is able to address associated problems and monitor the progress of future goals.

2. Who is appropriate for FOCUS?

FOCUS is intended for families with at least one child aged 5 and over, Transitional Age Youth (TAY) (ages 18 to 25), and Adults (ages 26 to 59) in our Directly Operated programs and school-based providers. This PP is appropriate for both military and civilian families who have experienced deployment(s), traumatic or loss event(s) resulting in a disruption of family functioning, personal adaptation, and related psychological difficulties.

3. Does the client need to have a specific diagnosis to receive FOCUS?

No. FOCUS is intended for military and civilian families who are having difficulties adjusting to and dealing with the stressors associated with deployment(s) and a range of traumatic event(s). The Department encourages clinicians to use their clinical judgment to determine if FOCUS is an appropriate model for the family being served. Furthermore, FOCUS is generally not the best practice for clients actively using alcohol or drugs, actively psychotic, actively manic, or at high risk for suicide or homicide. Clients presenting with any of the above issues should be referred to a higher level of care.

4. What does the treatment consist of?

FOCUS utilizes couple and family shared narratives about deployment(s) and/or traumatic event(s) to increase communication, resiliency, and to provide better support for one another. This is accomplished while family members express and explore their understanding of reactions to the deployment(s) and/or traumatic event(s). Families also work on identifying and building upon their existing strengths and positive coping strategies to work more effectively as a team.

5. What is the length of treatment?

FOCUS is an 8-session program designed to have each session used as a stand-alone intervention. This makes FOCUS flexible so military families can benefit from the intervention regardless of missed sessions or truncated time tables associated with pre-deployment, deployment and post-deployment issues.

6. What are the eight sessions?

FOCUS is divided into the following eight sessions:

Session 1: Introducing Parents to FOCUS
Session 2: Constructing Parent's Narrative Timelines
Session 3: Introducing Children to FOCUS
Session 4: Constructing Children's Narrative Map
Session 5: Preparing Parents for the Family Session
Session 6: Developing a Family Narrative
Session 7: Building Family Resiliency Skills
Session 8: Preparing for the Future

7. What are the core interventions of FOCUS?

The core interventions for FOCUS are:

- Assessment (Procedure Codes 90801 and 90802)
- Family Psychotherapy (Procedure Code 90847)
- Collateral (Procedure Code 90887)
- Individual Psychotherapy (Procedure Codes H0046, 90804, 90806, 90808)

Other interventions which may be appropriate during the course of the 8 sessions may include:

- Targeted Case Management (Procedure Code T1017)

The use of targeted case management may be appropriate if providing these services will assist in the reduction of the effects of the deployment(s) and/or traumatic event(s) on the family.

8. Can FOCUS be used in individual treatment?

Although some individuals may benefit from resiliency training, FOCUS was designed to assist the family as a unit. FOCUS can also be used for couples as well as single parent families who have a child between the ages of 5-18.

9. What happens if the family misses a session?

Ideally, all 8 FOCUS sessions should be completed without any interruptions. However, each session was designed as a separate intervention. Consequently, families who miss sessions due to pre-deployment, deployment, and post-deployment issues are allowed to interrupt treatment whenever necessary. Sessions may also be combined, offered multiple times per week or conducted with a co-therapist to allow maximum flexibility.

10. Who can provide this PP?

At this time the developer only allows clinicians (Masters level and higher, registered/waived and higher level clinicians) to be the primary leads in treatment. Paraprofessional staff can provide support with check-ins and case management.

11. What role can a psychiatrist and medication play with this practice?

Generally in this model, clients are not seen for a medication evaluation by a psychiatrist. On the other hand, there may be certain circumstances where a clinician may determine referring a client for a medication evaluation is appropriate. In these cases, not providing such services may be more harmful to the client's well-being and may prevent the client from returning to their previous level of functioning, especially when additional symptoms are resulting in severe impairments.

12. Can a client from one of the Mental Health Services Act's (MHSA) Client Supportive Services (CSS) Programs (Wellness, Field Capable Clinical Services, or Full Service Partnerships) or non-MHSA programs receive FOCUS?

Yes. Any client receiving services in one of our MHSA CSS or non-MHSA programs can receive this and any EBP. The service will be claimed to the current MHSA plan in which the client primarily receives his/her services, NOT to PEI.

13. Can the client receive FOCUS along with other EBPs?

Clients can receive 2 practices simultaneously only when clinically indicated. However, the use of multiple practices for PEI clients should happen very infrequently.

14. What is the required training and certification protocol?

The required training protocol has 4 parts. First, it begins with a six-hour, web-based program which is designed to provide an overview of FOCUS services, background information related to the impact of deployment on families, and to prepare the Resiliency Trainees for the live training component. Second, a three-day, in-person training or "Basic Course" is required which provides detailed instruction regarding how to conduct the full range of FOCUS services. Third, after the in-person training, weekly supervision by a FOCUS staff is required for at least 10 families. Fourth, the final step is a one-day, "Advanced Course" to be completed after the trainee has successfully provided FOCUS to 10 families.

15. Is "train the trainer" available for FOCUS?

No. The Department does not currently provide "train the trainer" as an option.

16. What are the outcome measures for FOCUS?

There are two outcome measures which are required for FOCUS:
-McMaster Family Assessment Device (FAD)

-Outcome Questionnaire (OQ)

17. Can the clinician claim for completing the outcome measure?

No. Administering an outcome measure is not a claimable service. There are two exceptions: (1) if the primary clinician closes the case as a result of referring the client to another agency, and at discharge, completes the outcome measure; or (2) if the outcome measure is completed during a billable session, and not over the phone or at home by the client.

FUNCTIONAL FAMILY THERAPY (FFT)

1. What are the 3 Phases of treatment during FFT?

The 3 Phases of treatment during FFT include:

1. Engagement and Motivation Phase

a. During the engagement and motivation phase of treatment the practitioner focuses on developing an alliance with the family, reduce negativity/blame and resistance, improve communication, minimize hopelessness, develop a family focus, increase motivation for change and reduce dropout potential.

2. Behavior Change

a. During the behavior change phase of treatment the practitioner focuses on development and implementation of individualized change plans, change presenting high risk behavior and build relational skills (e.g. communication, parenting, etc.).

3. Generalization Phase

a. During the generalization phase of treatment the practitioner focuses on maintaining/generalizing change, preventing relapses and providing community resources necessary to support change.

2. What is the age range for FFT?

FFT is to be provided to families where the identified client is between the ages of 10-18.

3. What is the focus of treatment for FFT?

FFT is intended for families where youth, ages 10-18, are experiencing severe behavior and/or conduct disorders.

4. What is the treatment modality?

FFT is provided in family group settings.

5. Where can FFT be provided?

FFT is primarily provided in the family home, but may also be provided in the community and in an office setting for the comfort of the family.

6. How many family facilitators are needed?

FFT family sessions are conducted by only 1 FFT practitioner.

7. What is the average length of treatment?

The average length of treatment is 12 sessions over a 3-4 month period.

8. How often should FFT sessions be conducted?

FFT sessions are conducted as often as need by the family; generally the first 3 sessions of engagement and motivation are conducted in the first 10 days of treatment, then sessions are typically conducted weekly. Session length is approximately 60-120 minutes.

9. What are the “Core Interventions” for FFT?

The “Core Interventions” include:

- i. Assessment
- ii. Collateral
- iii. Family Psychotherapy

10. Do you have to be licensed clinician to implement FFT under the PEI Plan?

Yes. Please see current version of the County of Los Angeles – DMH, “A Guide to Procedure Codes” for specific Rendering Provider eligibility.

11. Is there a “train the trainer” model for FFT?

No. Please see question below for internal agency training.

12. What is the training protocol for new agency staff/when there is staff turnover?

The training protocol for new agency staff/when there is staff turnover includes (Replacement Training Series):

- i. Initial Clinical Training (2.5 days)
- ii. Follow-Up Training #1 (2 days)
- iii. Follow-Up Training #2 (2 days)
- iv. Follow-Up Training #3 (2 days)

13. What are the required Outcome Questionnaires for FFT?

DMH PEI Outcome Measures Application Requirement: The outcome measures should be administered pre- and post-treatment. Additionally, if the FFT treatment extends beyond 6 months, an update for each measure is required every 6 months. The required outcome measures are the following:

- Youth Outcome Questionnaire (YOQ)
- Youth Outcome Questionnaire-Self Report (YOQ-SR)

CiMH/Developer Requirement: Each clinician is required to enter information into the Clinical Services System (CSS). The CSS is available online through the developer’s website. The CSS includes:

- i. Progress Notes (for each session)
- ii. Counseling Process Questionnaire (administered every other session)
- iii. Client Outcome Measure (administered post therapy)
- iv. Therapist Outcome Measure (administered post therapy)
- v. YOQ (administered pre and post therapy)
- vi. YOQ-SR (administered pre and post therapy)
- vii. OQ (administered pre and post therapy)

14. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs and YOQ-SR)?

Administration can be completed by a trained non-clinical or clinical staff. Scoring and interpretation can be completed by a person enrolled in a graduate degree

program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waived staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

GROUP COGNITIVE BEHAVIORAL THERAPY FOR MAJOR DEPRESSION (GROUP CBT)

1. Who is appropriate for Group CBT?

The developer intended this Evidence Based Practice (EBP) to be used with individuals experiencing a depressive disorder.

2. What is the age range for Group CBT?

The Department has decided to use Group CBT for Transitional Age Youth (TAY, age 18-25), Adults (age 26-59), and Older Adults (OA, age 60+).

3. Are the diagnoses of Major Depressive Disorder or Dysthymia required for Group CBT?

No, clients do not require a diagnosis of Major Depressive Disorder or Dysthymia. However, the model is intended to treat symptoms of depression. The Department encourages clinicians to use their clinical judgment to determine if Group CBT is an appropriate model for the client.

Consistent with DMH policy, the client must meet criteria for an included eligible diagnosis in order to claim services to Medi-Cal.

4. Can Group CBT be offered to all clients presenting with depressive symptoms?

Group CBT is more successful with the PEI population versus the serious and persistent mentally ill (SPMI) population. Group CBT is generally not the best practice for clients currently abusing or addicted to alcohol or drugs, currently psychotic, those diagnosed with a mental health disorder other than a mood disorder (such as PTSD), or clients with personality characteristics which may alter the group dynamic.

5. Who can provide Group CBT?

The Department only allows trained psychotherapists to be the primary lead/clinician for the group. Trained psychotherapists include licensed, registered, or waived MD/DO, Ph.D/Psy.D., LCSW, MFT, NP/CNS, RN, and student professionals in these disciplines with a co-signature. Paraprofessional staff can provide support with check-ins, homework, and case management. Paraprofessional staff can co-facilitate the CBT Group; however the primary clinician must take lead and, in this situation, the group can only be claimed as group rehab (H2015), not group psychotherapy (90853).

6. What is the length of treatment?

Group psychotherapy is offered one time per week for 12-16 weeks, depending on when the group completes all four sessions of the three modules. Ideally the client should commit to 12 weeks. The weeks do not have to be consecutive; thus the total time allowed is up to 16 weeks. The clinician should ensure that all 12 topics are discussed in the 12-16 week timeframe.

This model supports an orientation session at the beginning of treatment and a relapse prevention session at the end of treatment. These two sessions can be added so long as the entire course of treatment stays within the 16 week limit.

This practice may be extended up to 20 weeks if the Health module is added so long as the clinical appropriateness of extending the practice is clearly documented.

7. According to the developer, group sessions can be either 1.5-hours or 2-hours. What is the Department's requirement?

There is no Department mandate limiting the time frame of groups. Clinicians can provide a 1.5-hour or 2-hour group on a weekly basis.

8. According to the developer, the groups can be open or closed. Does the Department mandate one or the other?

The Department does not mandate that groups be open or closed; however recommends an open group to allow new clients to enroll every 4 weeks upon the completion of a module. It is also recommended that the clinician orient new members to the group at start of each module. Clients are required to attend Session 1 of whichever module they enter into the group.

Clinicians should be mindful that this may influence the group's dynamics. Group structure should be based on your clinic and client needs; however an open group allows clients access to services within a shorter time frame versus waiting for a group to commence.

9. Does the Department require a certain number of participants in each group session?

There is no Department mandate regarding the number of participants; however there needs to be at least 2 clients in order to claim the procedure code for group psychotherapy.

The recommended ratio for Group CBT is 8-10 participants to 2 clinicians per group.

10. Can the clinicians incorporate other topics and treatment modalities besides CBT in the groups?

Group CBT therapy is limited to the treatment protocols contained within the Group CBT for Major Depression manuals. This EBP does encourage a "tailor approach" by allowing the group facilitator to use clients' life examples and illustrations to make CBT concepts applicable to the clients' lives.

11. Is homework required between each group session?

Yes. Clinicians should review the client's homework, weekly, in the group session.

12. What procedure codes should be used for Group CBT?

The procedure codes for Group CBT are:

- Assessment (Procedure Code 90801 and 90802)
- Group Psychotherapy (Procedure Code 90853)
- Group Rehabilitation (Procedure Code H2015)* (HE, HQ**)

*To be used if a paraprofessional co-facilitates the group with the clinician

**For Contract Providers submitting electronic claims to the Department

Other services, including case consultation, medication support, collateral sessions, or crisis intervention, may be offered to address emergent client needs and individual therapy may be utilized if a client misses a group session; however the client should be referred to a higher level of care if they require ongoing services.

13. When can you use Individual Psychotherapy (Procedure Code H0046, 90804, 90806, or 90808)?

Individual psychotherapy should only be used to “make-up” a missed group psychotherapy session. Ongoing participation in individual psychotherapy is not part of the Group CBT model and could discourage group participation and negatively impact the benefits the client might otherwise gain from Group CBT. Individual psychotherapy with the same clinician to address the issues also discussed in group is discouraged by the Department while the client is participating in Group CBT.

14. What about case management?

Case management can be utilized to keep clients engaged in treatment or to connect them to other non-core services or community resources. For example, a client who is homeless will be more engaged in treatment if housing assistance is also provided. For those clients who may need long-term or more intensive treatment, the clinician can identify appropriate referrals. In these situations, the Group CBT clinician retains clinical responsibility over the case until it is successfully transitioned into the appropriate setting.

15. Can the clinician claim for group preparation on Community Outreach Services (COS)?

No. The Department does not permit use of COS to claim for group preparation.

16. Can a client from one of the Mental Health Services Act (MHSA) Community Services and Support (CSS) programs (Wellness, Field Capable Clinical Services, or Full Service Partnership) or non-MHSA programs receive this EBP?

Yes. Any client receiving services in one of our non-MHSA or MHSA-CSS programs can receive this EBP as well as other EBP interventions. In such instances, the service will be claimed to the MHSA plan/Level of Care in which the client receives their primary services—and NOT to PEI. For example, a CSS

Wellness client can participate in Group CBT if the client meets the criteria for this practice. However, the services for this client will continue to be billed to the "MHSA_Fam_Focused_Wellness Svc" plan, not the "PEI Adult: Ages 26-59, Plan No. 2092". The clinician will identify the EBP as "Group CBT" (2J). PEI outcome measures are not required when the client is receiving EBP services in a different plan (i.e., not PEI).

17. Can a client receive Group CBT along with another PEI EBP?

The goal of PEI services is to help the client move forward quickly in coping with their mental health challenges. Therefore, the Department expects that the use of multiple practices for PEI clients would occur infrequently. The clinician would need to consider duplication of services, overwhelming the client with services/expectations, and, most importantly, the clinical necessity of adding another practice to meet the client's needs.

18. What happens if the client successfully completes Group CBT?

The client will be discharged and their case will be appropriately closed. They may return, if needed, should they benefit from another course of Group CBT or alternative interventions.

19. What is the required training protocol?

The Department requires the clinician to attend the two-day, Initial Adult Group CBT training. Upon completion of the two-day training, trainees participate in consultation calls with the trainer and their clinic's Group CBT team for the duration of 16 weeks. The trainees will audio record their group sessions and download the recordings to the trainers secure website to review. A minimum of one recording for each of the three modules is required to complete the training. The clinician must also administer and upload the PHQ-9 each week on each client.

Clinicians must also attend the one-day Booster Training, typically held 2-3 months after initial training.

20. Does Group CBT require a trained supervisor as part of the Adult CBT Team at a clinic?

According to the EBP, formal supervision by a licensed clinician is required. The Department encourages each program to select a "champion" who will be trained in Group CBT and can provide implementation and clinical support for the EBP. The "champion" should have prior training in CBT, such as the course offered at Harbor UCLA.

21. Is "train the trainer" available for Group CBT?

The developer does not currently permit "train the trainer".

22. Can interns get trained in and offer Group CBT?

Yes, interns can be trained in Group CBT. Interns who complete all components of the training will receive provisional authorization to claim Group CBT services. Interns will require supervision by a licensed clinician to claim Group CBT services to the PEI Plan.

23. How do I participate in the weekly phone consultation?

Staff must complete the initial two-day training and the trainer must provide the individual access to the website to download the audio recordings of the group sessions. Staff must log into the Group CBT Website, www.adoptebp.com, to register. The website and the recordings uploaded to this site are used for the weekly phone consultation and to communicate and share information regarding CBT implementation and compliance. This website and the use of recordings should only be used during the training period. Clinicians should stop using the website and recording sessions once they have become certified in this EBP.

24. What are the required outcome measures for Group CBT?

There are two outcome measures for Group CBT:

- Personal Health Questionnaire Depression Scale-9 (PHQ-9) for ages 18+
- Outcome Questionnaire (OQ) for ages 18+

25. When should the outcome measure be completed?

Outcome measures are to be completed 14 days from the date of the First EBP Treatment Session to collect the “Pre” measures, and 14 days from the date of the Last EBP Treatment Session to collect the “Post” outcome measures. PEI outcome measures should also be administered at the 6 month mark (an “Update”) to clients enrolled in an EBP that lasts 6 months or longer.

26. Can the clinician claim for administering the outcome measure?

No. Administering an outcome measure is not claimable to Medi-Cal.

INDIVIDUAL COGNITIVE BEHAVIORAL THERAPY (Ind CBT)

- 1. Who is appropriate for Individual CBT?**
Ind CBT is intended as an early intervention for individuals who are experiencing or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma which impact various domains of daily living.
- 2. What is the age range for Ind CBT?**
Currently the Department supports utilization of Ind CBT for Transitional Age Youth (TAY, age 18-25), Adults (age 26-59), and Older Adults (OA, age 60+) at our Directly Operated clinics only.
- 3. Are there specified diagnoses required for Ind CBT?**
No, clients do not require specific diagnosis to participate in Ind CBT. The model is intended to prevent or treat early onset of symptoms of depression, anxiety, and effects of trauma that may impact functioning in various domains of daily life. The Department of Mental Health (DMH) encourages clinicians to use their clinical judgment to determine if Ind CBT is an appropriate model for the client. Consistent with DMH policy, the client must meet criteria for an included eligible diagnosis in order to claim services to Medi-Cal.
- 4. Who can provide CBT?**
Within DMH, Ind CBT may be provided by licensed, registered, or waived MD/DO, Ph.D/Psy.D., LCSW, MFT, NP/CNS, RN, and student professionals in these disciplines with a co-signature provided they have had (or are currently receiving) specialized training in CBT. Specialized training **MUST** be preapproved by the Department; and may include: classes received at the graduate level as well as the Advances in CBT Class provided throughout DMH. The clinician **MAY** be asked to complete a cognitive case conceptualization form and pass a brief exam to show proficiency in CBT.
- 5. What is the length of treatment?**
Treatment length for Ind CBT ranges from 18 to 52 weekly sessions depending on client's clinical needs and treatment response. Clinical tasks, to be completed during a course of Ind CBT include: developing diagnoses, treatment planning from a case conceptualization perspective, and the provision of CBT intervention protocol.
- 6. What is the length of treatment sessions?**
Ind CBT is provided during a 45-50-minute weekly session. The practice recommends a 90-minute session for those involving the use of prolonged exposure with response prevention.
- 7. Can the clinician incorporate other topics and treatment modalities besides CBT?**

Adherence to the treatment protocol is required for Ind CBT. For this intervention, treatment is limited to the use of CBT interventions and methods of conceptualization. Ind CBT allows for “tailoring” of CBT conceptualizations and interventions to address individual treatment goals

8. Is homework required between each session?

Yes, homework is an important part of ensuring treatment generalization to the client’s daily life. Homework is tailored to client’s treatment goals and reviewed weekly during the therapy session.

9. What procedure codes should be used for Ind CBT?

The procedure codes for Individual CBT are:

- Assessment (Procedure Code 90801 and 90802)
- Individual Psychotherapy (Procedure Code H0046, 90804, 90806, & 90808)
- Family Psychotherapy (Procedure Code 90847)
- Group Psychotherapy (Procedure Code 90853)
- Target Case Management (Procedure Code T1017)
- Collateral (Procedure Code 90887)

Other services; including case consultation, medication support, or crisis intervention; may be offered to address emergent client needs. The client should be referred to a higher level of care if they require more intensive ongoing services.

10. What about case management?

Case management can be utilized to keep clients engaged in treatment or to connect them to other ancillary services or community resources. For example, a client who is homeless will be more engaged in treatment if housing assistance is also provided. For those clients who may need long-term or more intensive treatment, the clinician can identify appropriate referrals. In these situations, the CBT clinician retains clinical responsibility over the case until it is successfully transitioned into the appropriate higher level of care.

11. Can the clinician claim for preparation on Community Outreach Services (COS)?

No, DMH does not permit use of COS to claim billing for preparation of service delivery.

12. Can a client from one of the Mental Health Services Act (MHSA) Community Services and Support (CSS) programs (Wellness, Field Capable Clinical Services, or Full Service Partnership) or non-MHSA programs receive this Practice?

Yes, any client receiving services in one of our non-MHSA or MHSA-CSS programs can receive this PEI Practice as well as other PEI interventions. In such instances, the service will be claimed to the MHSA plan/level of care in

which the client receives their primary services—NOT to PEI. For example, a CSS Wellness client can receive Ind CBT if the client meets the criteria for this practice. However, the services for this client will continue to be billed to the "MHSA_Fam_Focused_Wellness Svc" plan, not the "PEI Adult: Ages 26-59, Plan No. 2092". The clinician will identify the EBP as "Individual CBT" (8A) on the IS drop down menu. PEI outcome measures are NOT required when the client is receiving PEI practices in a different IS billing plan (i.e., not PEI).

14. Can a client receive Ind CBT along with another PEI Practice?

The goal of PEI services is to help the client move forward quickly in coping with their mental health challenges. Therefore, DMH expects that the use of multiple practices for PEI clients would occur infrequently. The clinician would need to consider duplication of services, overwhelming the client with services/expectations, and, most importantly, the clinical necessity of adding another practice to meet the client's needs.

15. What is the required training protocol Ind CBT?

DMH requires clinicians to attend a 1.5 hour weekly class for 9 months and submit either a case conceptualization or audio recording of a session to the trainer.

In some instances, clinicians who have received specialized training in CBT treatment interventions and conceptualization may be certified to provide this PEI Practice within DMH. This training may have been received either at the graduate level or by attending the Advances in Cognitive Behavioral Therapy course offered through DMH. For clinicians who have not attended the Advances in CBT course but are claiming training through graduate training, they will be asked to submit a taped session along with a case conceptualization to designated DMH clinicians in order to ensure competency. These situations will be approved on an individual basis by the Practice Leads.

16. Does Ind CBT require a trained supervisor as part of the Adult Individual CBT Team at a clinic?

While it is not a Department requirement, it is highly recommended each program identify a clinical supervisor trained in CBT who **MUST** carry at least one active CBT client.

17. Is "train the trainer" a possibility with Ind CBT?

At this time, this intervention does not incorporate a "train the trainer" model.

18. Can students and interns get trained in CBT?

Yes, students and interns can be trained in Ind CBT. Those who complete all components of the training and are supervised by a licensed clinician will receive provisional authorization to claim Individual CBT services to the PEI Plan.

19. What are the required outcome measures for Ind CBT?

Clinicians will administer the General Measure (OQ-45.2) and symptom specific measures congruent the client's presenting problem in treatment. The outcome measures for Ind CBT are as follows:

General Measure:

-Outcomes Questionnaire 45.2 (OQ-45.2)

Focus of Treatment Specific Measure

-For Depression: Patient Health Questionnaire Depression Scale-9 (PHQ-9)

-For Anxiety: Generalized Anxiety Disorder 7-item Scale (GAD-7)

-For Trauma: University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-PTSD RI)

20. When should the outcome measure be completed?

Outcome measures are to be completed 14 days from the date of the First PEI Practice Treatment Session to collect the "Pre" measures, and 14 days from the date of the Last PEI Practice Treatment Session to collect the "Post" outcome measures. PEI outcome measures should also be administered at the 6-month mark (an "Update") to clients enrolled in a PEI Practice which lasts 6 months or longer.

21. Can the clinician claim for administering the outcome measure?

No, administering an outcome measure is not claimable to Medi-Cal.

MANAGING AND ADAPTING PRACTICE (MAP)

1. What are the requirements of becoming a MAP Supervisor?

To qualify to become a MAP Supervisor, the individual must have been awarded MAP Therapist Status and, according to DMH standards, be a licensed clinician. The process requires that the individual complete the MAP Supervision and Consultation Series training, which includes a 2 day supervisor training workshop, 6 months of consultation calls, and the supervising of 6 therapists new to MAP. Each of the 6 trainees must submit their valid portfolios to PracticeWise for review. Each of the 6 therapists must submit a valid portfolio with at least one primary outcome achieved. At least 2 of the 6 trainees must achieve MAP Therapist status.

2. Must one maintain MAP Therapist certification in order to maintain MAP Supervisor certification?

No, maintenance of MAP Agency Supervisor status will not require renewal of MAP Therapist Status (The exception to this is that individual who achieve MAP Agency Supervisor status via “grandfathering” are required to successfully pass the MAP Therapist Portfolio when their initial 3-year “grandfathering” period expires).

Note: Grandfathering refers to people who were trained by PracticeWise as MAP therapists before the portfolio was in place. In those cases, people have a 3 year period from their initial training under which they can operate as a MAP therapist in LA County, but at the end of that period they will need to submit a full therapist portfolio.

3. How does one maintain MAP Supervisor certification? Must you train 6 additional staff and have 2 more pass portfolio in that 2 year period?

No. The renewal is basically an update not a retraining, so they will either need to (a) successfully complete a supervisee, (b) submit a case from a current supervisee, or (c) submit their own MAP direct service case, along with the other docs required. Please note that PracticeWise is currently working on policy documents for this and you will know what you need to do long before the time comes in two years.

4. Once we have a MAP Supervisor, if they provided week long training and 6 months of consultation calls to staff, will those staff be “certified” MAP Therapists officially? Can they then take the Supervisor course?

Those staff will have to successfully pass their portfolio review to be certified in MAP and obtain their MAP Therapist Status. Once MAP Therapist Status is achieved, staff are eligible to continue on to the Supervision and Consultation Series.

5. Can MAP Supervisors supervise MAP staff who are already certified outside of the 10 max set by LACDMH?

Yes.

- 6. If an agency has two MAP Supervisors, can one do the training (in a formal 5-day sense) and the other do the follow-up consultation meetings? Will the training hours count toward the 15 the first person needs?**

We do not mind if agencies with multiple supervisors “tag team” on the training portion (e.g., three supervisors split up training duties, group their supervisees for a shared training event, and then each continue the supervision with their supervisees following the event) but a systematic “hand off” from one supervisor who does the training to others who do the clinical supervision is definitely not consistent with the spirit of the Agency Supervisor model. This issue is a little tough because therapists and supervisors do periodically get “reassigned” during the development period and if this is a rare event, we would not take issue, but if this is recurrent or systematic then it does violate the spirit of the model.

- 7. Can a licensed therapist who received MAP training from a MAP supervisor be eligible for DMH sponsored MAP Supervision and Consultation Series training?**

Yes, as long as they successfully passed their Therapist Portfolio review and achieved MAP Therapist status, they are eligible for the MAP Supervision and Consultation series training.

- 8. I read through the document on certification for PracticeWise and DMH but I'm not clear on which documents need to be submitted and to whom for MAP trainees receiving training from MAP Supervisors at the agency. Since they have not completed the 5 day training, they would not get a certificate, so what do I submit to PracticeWise and what do I submit to DMH?**

Upon completion of training, trainees must submit the portfolio to PracticeWise. Supervisors must also submit their trainee’s learning log along with their MAP Supervisor’s certificate to DMH for authorization to submit claims to MAP. Once the trainee has achieved MAP Therapist status, they must submit their therapist certificate to DMH.

- 9. Are there age restrictions for MAP? I have heard that the clients must be 4 yrs old regardless of what data is available in the PracticeWise PWEBS database? If there are age range cut-off's both top and bottom of the range, what are they?**

With MAP, a key part of service planning and revision involves the use of the PracticeWise EBS Database (PWEBS). The PWEBS Database summarizes over 450 studies involving mental health treatments for participants ranging in age from 0 to 23 and currently focuses on treatments that target anxiety, attention problems, autism spectrum, depression, disruptive behavior, eating problems, mania, substance use, suicidality, and traumatic stress. However, that literature is not uniform across problems, gender, ethnic groups, etc. (e.g., the age range of established treatments for Attention Problems is 2 to 13 years) and

the PWEBS literature review is not comprehensive for youth above age 18. Therapists are encouraged to probe the relevance of the available research to a given client or family and to use sound judgment in choosing a course of action. When therapists are operating outside the age range of the literature, they are typically expected to use best practices by adapting and extending approaches that work for groups of children “most similar” to the client in questions (in this case, closest in age). To the extent that there are departures from the literature, therapists should be aware that the uncertainty of achieving a positive outcome is increased, and thus especially conscientious use of outcome monitoring is warranted. MAP also incorporates a measurement plan into its direct service model, so that regardless of the strategies suggested by the literature, a MAP Therapist would be expected to measure and review the practices being used and the progress associated with those practices. (See document: Direct Service Workshop Overview)

10. May I treat TAY youth with MAP?

Under PEI, if you have TAY funding, you can treat TAY using MAP.

See answer to question # 9. When using MAP with clients over 18 years, it is very important to recognize the limits of the system. The review underlying the PWEBS is only systematic through age 18 years, so when going “beyond the literature” practitioners are encouraged to consider other sources of evidence that may be more directly relevant to the client’s characteristics (i.e., look at literature and literature review tools other than just the PWEBS). The PWEBS information is always about “similar” but not “identical” youth, so to the extent that the PWEBS does provide information about similar problem, gender, ethnicity, setting, etc. the generalization across age may be reasonable if not optimal. Also, we would encourage special attention to the “embracing diversity” issues to make thoughtful judgments about adaptations that may be necessary to the Practitioner Guide procedures to communicate them in a way that is appropriate for a young adult. Many of the other MAP components (e.g., PPMT, process guides) may translate more directly for use with older clients. Practitioners should be aware that the uncertainty of achieving positive outcomes is increased and especially conscientious use of outcome monitoring is warranted.

11. Are TAY Youth covered in PWEBSs?

The review underlying the PWEBS is only systematic through age 18 years, but it does include studies with participants over 18 years if youth under 18 are adequately represented in the study. This means that you may find results for youth above 18, but it will not be a thorough representation of the evidence base for those age groups.

12. We are hearing from some of our MAP trained staff that clients with ADHD cannot be seen in MAP. Our understanding is that it is not diagnosis, but Focus of treatment that drives the ability to use MAP. So, if you had a client

with a diagnosis of ADHD but a focus of treatment of Disruptive Behavior you could use MAP, yes?

Yes. The 4 target areas eligible for PEI are Anxiety and Avoidance, Depression and Withdrawal, Disruptive Behavior, and Traumatic Stress. The diagnosis of ADHD may or may not be eligible under PEI depending on the primary target area and focus of treatment. If the primary target area is one of the 4 target areas eligible under PEI, then the service and claim are eligible for PEI.

- 13. A number of the supervisors noted that they had recently heard through admin calls and LACDMH documentation that they are not able to claim for MAP for youth with depression issues under 8 years old. Likewise, their understanding is that they could not claim for MAP if kids fell under the lower age thresholds for the outcome measures. I am not sure if this is completely accurate, and wanted to be able to inform both my supervisees and our other training staff if this is in fact the case. Any insight into this issue would be much appreciated!**

Please see answer to question # 9 above. In addition, on admin calls and LACDMH documentation, the age limits are specific to standardized measurement normative age range, which have implications for outcome data collection only.

- 14. Which of the PracticeWise Online Resources services are required for a user to pursue or maintain MAP Therapist or MAP Agency Supervisor Status?**

The Progress and Practice Monitoring Tools (PPMT, a.k.a. Clinical Dashboards), Practitioner Guides, and PWEBS Database.

- 15. Do those completing the MAP Supervision and Consultation Series have to submit all 6 trainees' MAP therapist portfolios for review at the same time?**

No. It is not necessary to submit all of the Therapist Portfolios at the same time. Sometimes this is recommended to minimize confusion, but it is not necessary.

- 16. Is there a website where archived webinars are stored to view for clinicians that have not gone through live-webinars for standardized measures?**

The Webinar is on both the CIMH and PracticeWise websites.

- 17. How can the supervisor ensure that data is correct on the PPMT if someone else is monitoring/collecting the outcome measure data? It seems hard for the responsibilities of MAP to be dispersed. Why can't we write the names of assessments/measures (i.e. ECBI, PHQ-) in case notes if it's such an integral part of treatment?**

It is the therapist's responsibility to administer, collect and monitor PPMT data and client progress. A MAP supervisor has the responsibility to ensure that the therapist is competent in capturing accurate data on the PPMT through chart review and supervision.

Clinicians can refer to a specific measure in their case notes if they clearly denote the clinical utility of the measure and how it relates to their interventions and client improvements.

- 18. If a client is in MAP, but the clinician feels that the parent would benefit from Triple P, would the clinician be able to allow the parent to do the Triple P Model and then resume MAP afterwards?**

Yes, If Triple P is the intervention suggested that will work for the client.

- 19. Will DMH accept MAP certificates for staff trained by in house supervisors that then move to another agency?**

PracticeWise has established a pathway for staff to maintain their MAP Therapist Status when moving to a new agency. Please contact PracticeWise for the transfer packet.

- 20. Can consultation by a MAP therapist with a non-MAP trained staff (e.g. MD) be claimed to MAP?**

Yes.

- 21. Staff is not clear about administering RCADS, so will there be training to help them?**

The Agency will have to train the staff on how the agency wants the RCADS done at their agency; however, there is a Webinar on the CiMH and PracticeWise websites. Please contact Cricket Mitchell at CiMH for further assistance (cmitchell@cimh.org).

- 22. Has DMH established a protocol for agencies regarding utilizing case managers with MAP clients who are not trained in MAP with the changes to PEI claiming?**

Case Managers can claim for services provided within their scope of work as long services are coordinated with the MAP Therapist, it is clinically appropriate, and there is documented justification of services.

- 23. If I have not been trained on the outcome measures, how do I receive training?**

You can receive training through the link to CIMH's website where you will find recordings of the five measure-specific webinars:

[http://www.cimh.org/Services/Child-Family/Evidence-Based-Practice/Managing-and-Adapting-Practice-\(MAP\)/Webinar-Recordings.aspx](http://www.cimh.org/Services/Child-Family/Evidence-Based-Practice/Managing-and-Adapting-Practice-(MAP)/Webinar-Recordings.aspx)

Please direct questions about the LA PEI MAP outcome measures to Cricket Mitchell, cmitchell@cimh.org or 858-220-6355.

- 24. I have not yet been trained on the outcome measures. If I do not have them completed within the first 30 days of treatment, should I administer them at all?**

You can receive MAP outcome measures training through webinars posted on CiMH's website (see response to # 22).

MAP does not have the first 30 days of treatment policy when it comes to pre-treatment data. Our interest in the completion of outcome measures has to do with assessing the functioning of the client, within the valid administration guidelines of each measure, for two purposes: (1) providing clinically useful information to guide treatment; and, (2) document treatment-related improvements in functioning.

From an outcomes perspective, the measures should be completed at pre-treatment, pre-MAP intervention. The farther one gets into treatment, the administration of measures no longer represents a pre-treatment assessment.

There is no absolute cut-off point. If the measures are not collected pre-treatment, they're not useful from an outcomes perspective. However, if the client was not seen within those 30 days, and the clinician feels as if the administration would still be pre-treatment, and be an accurate reflection of functioning before the MAP intervention, then it would be worthwhile. In terms of guiding clinical intervention, early and regular measurement is most useful, but even if pre-treatment assessment is missed, the "better late than never" rule applies.

25. Will I fail my portfolio if I don't have baseline measures?

No, baseline assessment is not specifically required to pass a MAP Therapist Portfolio review. A number of considerations are made in scoring dashboards for portfolio review. The score for the progress data availability criteria may receive a lower rating if multiple data points from multiple measures are not included. However, a low score on one criterion may be "offset" by a high score on another criterion.

26. Must I include the PPMT in my final chart before termination?

Yes, the PPMT (first page that shows the graph only) will need to be in your chart.

27. Must my progress notes cite specific MAP Practice Elements in order to pass an audit?

No.

28. I heard that we are only allowed to use one or two practitioner guides per session. What happens if we use more?

There is no "hard and fast" rule about the number of practitioner guides to use per session. The recommendation to limit use of multiple practitioner guides within a single session is designed to promote focus and depth in intervention. Ultimately, decisions about the number of guides to use and the depth to which each guide is addressed during a session is a clinical judgment. However, prior

analyses of care patterns have identified a tendency toward use of many, lower “dose” practices, e.g., numerous practices endorsed for a single session, in actual care systems, whereas effective interventions tend to be characterized by fewer practices that are implemented with greater depth.

The MAP model guides but does not explicitly restrict or limit the number or ordering of practices used. However, MAP advocates that the selection of practices emphasizes a high degree of focus and that implementation of practices occur with sufficient intensity and depth to help clients develop expertise with the practice and effect change in their life as desired.

It is important to remember that the PPMT was created as a method for clinicians to keep track of their patterns of practice when numerous Practitioner Guides are endorsed for a single session. It can become hard to remember exactly what occurred in each session. The MAP Model emphasizes parsimony in selecting practices in sessions and on your PPMT so that you represent the things that were covered most thoroughly in the session. It is not necessary to endorse practices that were merely mentioned or reviewed in brief.

29. Can I claim for MAP if I have youth with secondary problem areas including things like bipolar, eating disorders, or autism?

You can claim PEI as long as the primary focus of treatment is one of the four target behaviors: Anxiety, Depression, Disruptive Behaviors, or Traumatic Stress, regardless of the diagnosis. However, if the youth has more severe symptoms and/or requires more intensive treatment, he/she may not meet the criteria for the PEI target population and require services through a non-PEI Program.

30. Is family therapy considered part of MAP? It comes up in my PWEBS searches but there are no practitioner guides.

Yes, family therapy practices are included in MAP. Because the standard MAP terminology differs from that of the various family therapy literatures, learning the overlap and translations between terms may require a bit of extra initial effort. In MAP, family therapy structure, processes, and practices are represented in several ways.

One way that the MAP represents the structure of family therapy is through the “format” codes in the PWEBS, which indicate the patterns of participation in sessions. For example, interventions described as family therapy in the literature may have been tested in various formats such as conjoint family therapy which is coded as Family format, one-person family therapy which is coded as Family One format, dyadic family therapy which is coded as Parent Child format, or multifamily group which is coded as Multifamily format. Other formats such as Parent or Parent Group may also be coded as appropriate.

The various family therapy approaches also include numerous different practices that are coded into the standard practice elements wherever possible. For

example, common family therapy techniques such as encouraging the family to speak directly to each other, encouraging interaction by asking the family to discuss something, etc. are addressed in the Communication Skills practitioner guide. The set of Cognitive practitioner guides incorporate family therapy techniques such as reframing, restructuring, or reconnection (e.g., recall and label positive feelings and thoughts about someone). The family therapy technique of validating changes with positive reinforcement is addressed as Therapist Praise/Rewards.

Family therapy strategies for working with boundaries and alliances are also covered in some of the standard practice elements, such as strengthening alliances by finding areas of common interest and encouraging their pursuit (e.g., Activity Selection, Attending), strengthening boundaries (weakening alliances) by collaborative rule setting between enmeshed and non-enmeshed adult with regard to an enmeshed child (Behavioral Contracting, Stimulus/Antecedent Control), opening up closed systems and detriangulation by focusing back on the parties in conflict, promoting direct address, labeling covert issues, and such (Communication Skills), etc.

Further, “other practice” descriptions are used in the PWEBS to provide additional specificity or to describe practices that are under consideration for inclusion in the standard practice element set. For example, aspects of the “Joining” technique are included in the Relationship/Rapport Building and Engagement practitioner guides but “Joining” is also explicitly identified as an “other practice” in the PWEBS.

The Family Therapy practice element itself has a few unique features. This practice emphasizes “shifting patterns of relationships and interactions within a family” and may be thought of as relational restructuring. As previously indicated, the specific practices and exercises for doing this are often characterized by the other practice elements mentioned above. The family therapy practice element is coded in addition to the other specific practice elements, when practices are applied to restructuring family relationship. Also, the practice descriptions in some of the family therapy literature are not detailed enough to code the specific practices used, so the family therapy practice element may be coded to indicate these interventions.

PracticeWise regularly re-evaluates how well the practice coding system reflects diverse literatures but also integrates these diverse literatures into a coherent set of common elements. The MAP system was designed to be a transtheoretical infrastructure that links to a common set of evidence, but part of the continual learning process of MAP is the ongoing translation from each professional’s preferred terminology to the common constructs and language of the MAP system.

31. May I use other EBP materials when I am employing MAP?

Yes. The MAP system provides tools and resources to promote high quality evidence-based practices, but there are many other good tools and resources available. When identifying and selecting appropriate alternative EBP materials for MAP, it is good practice to consult the PWEBS to identify those materials and models with the “best evidence” for similar clients and follow a structured decision-making process to guide generalizations as needed. When recording the use of these other evidence-based practices on your PPMT, you may either choose the practice element from your PWEBS search that best represents the generic concept of those materials you used. You may also write these practices in as an “Other” by using the name of the materials from the other EBP.

32. What counts as a "clinical event" in MAP? Can I include collateral sessions or teacher meetings as clinical events?

Clinical events may also be thought of a therapeutic interaction, clinical contacts, or intervention sessions during which components of the MAP system were used. If collateral sessions or teacher meetings include an active therapeutic practice then they may be “counted” as a clinical event.

33. Do my PPMT measures have to align directly with my CCCP goals?

This is not technically required, but is strongly encouraged. Typically, PPMT target behaviors and measures should be closely related to CCCP goals since they both address client’s needs and impairments and measure progress of treatment. If a discrepancy between the CCCP and PPMT does exist, a compelling rationale should be apparent.

Sometimes clinicians write broad CCCP goals that encompass a variety of behaviors within a symptom cluster. For example, “Client will reduce depressive symptoms including crying, isolating, angry outbursts, and sulking from 10 times a week to 3 times a week.” When translating this goal to the PPMT, it may be helpful to break the component behaviors down for individual measures or find a way to measure them as a Gestalt. In the above example, the therapist might measure: 1) caregiver report of youth’s angry outbursts at home per week, 2) youth’s report of crying episodes per week, 3) youth or caregiver reports of overall depression severity level that week.

Overall, your CCCP goals are best used to inform your PPMT measurements, consistency between these two should help to make it easier to keep track of progress of goals. They are meant to inform each other to benefit treatment planning and conceptualization.

34. Can certified MAP Therapists lead "MAP Support Groups" at their agency to provide informal clinical and PRACTICEWISE Tool support without being a MAP Supervisor?

Yes. Peer support, consultation, and review are encouraged and may be an effective and cost effective strategy for MAP quality assurance and improvement. Because this is different from MAP agency supervision and training, support

groups will not qualify individuals for any advancement or promotion within the MAP Professional Development Program.

35. How much are the fees if I have to resubmit my portfolio and how do I order a new portfolio review?

Additional portfolio reviews can be purchased through the www.practicewise.com website. The therapist or supervisor will need to log in to the site and click on the link titled "Subscribe." Under this link the individual may choose to Purchase Portfolio Review. Current pricing and a group order form are also available on that web page. Email requests may also be addressed to support@practicewise.com.

36. What should I do if I do not receive the MAP Update emails from Practicewise?

This generally occurs either because the email address registered to your account is incorrect or the email is being screened as junk mail by your email provider. To verify that the correct email addresses listed for your account, go to www.practicewise.com, login to your account, click on your username in the upper right hand corner, and update the email address field. If the email address is correct, please check your junk mail folder or contact your system administrator to verify that email from practicewise are approved for receipt. If the problem continues, send a notice to support@practicewise.com to request assistance.

37. What is the current version of PPMT?

Version 3.07 was released on 9/29/2012.

38. Is it required that I save my PWEBS searches into my PPMT notes page? I heard that if you don't do this you will fail your portfolio review.

No. The PWEBS search may be submitted in the notes page of the PPMT, but it is also acceptable to submit it in another readable form (i.e., pdf .doc, fax, hard copy). During the review process, you will be notified if the submitted format is unreadable.

39. Is there a telephone number where I can call the PRACTICEWISE Central Office?

The phone and fax service number for the PracticeWise central office is 321-426-4109. However, the best way to get a prompt response to a question is to send an email to support@practicewise.com.

40. How many consultation calls must I participate in to pass my portfolio review?

Twelve (12) direct service consultation calls are required to pass the MAP Therapist Portfolio promotion review and six (6) supervision and consultation calls are required to pass the MAP Agency Supervisor Portfolio promotion review.

- 41. How long do the Training Event pages stay active?**
Training Event pages used to stay active for about 9 months, but due to repeated requests for extensions PracticeWise has extended these pages for several years.
- 42. Will PracticeWise provide Training Event pages for MAP Supervisors when they lead trainings at their agencies?**
No. PracticeWise does not provide web support for internal agency training events.
- 43. How do Supervisors determine the RSVP Code for tools subscription for their supervisees?**
Supervisors should contact the individual assigned as the group administrator by their agency. If you have difficulty identifying your agency's group administrator, you may send an email request to support@practicewise.com and PracticeWise will try to assist you in identifying the assigned group administrator for your subscription.
- 44. Do I have to hold 20 clinical events across at least two cases or for two individual cases to pass my portfolio MAP Therapist review?**
A total of 20 clinical events across at least two (2) cases is required. For example, two (2) cases with 10 events each would be sufficient experience.
- 45. Must I achieve a positive outcome with my cases in order to pass my MAP Therapist portfolio review?**
No, it is not necessary to achieve positive outcomes with your cases to pass the MAP Therapist Portfolio promotion review.
- 46. If I send in my portfolio via email, how do I provide a signature on the case record?**
An electronic signature is acceptable if the portfolio is submitted via email from the certifying account. You may create an electronic signature by typing your name on the line that reads "Signature" on the Case Record sheet of the portfolio.
- 47. When is the Therapist Portfolio due?**
The Therapist Portfolio is due within one year of completing the Direct Services Training. Therapists are eligible to submit their portfolios for review as soon as they have completed 12 hours of consultation over a period of 6 months. The cost associated with the review of the Therapist Portfolio is included in the Direct Services Training contract which expires 1 year from the completion of the Direct Services Training. Submissions beyond that date will be accepted but there will be an additional cost for the review.
- 48. What do Level 1 and Level 2 failure mean in the portfolio review process?**

Level 1 Review is performed to determine if the portfolio submission is properly completed.

- a. If results of the Level 1 Review are not satisfactory, then the submitter will be notified of problematic items and be allowed to resubmit within thirty (30) calendar days.
- b. If results of the Level 1 Review for the resubmitted items are not satisfactory, then the review will fail and a new review process will need to be initiated.

Level 2 Review is performed to determine if the portfolio meets quality standards.

- c. If Level 1 and Level 2 Reviews were completed successfully, the submitter will receive the appropriate Award of Status.
- d. If Level 2 Review was not completed successfully, then the submitter will be notified of the problematic items and be eligible to initiate a new review process for a resubmitted portfolio thirty (30) days after an initial review.
- e. If Level 2 Review was not completed successfully during the review of a resubmitted portfolio (i.e., upon second failure), then the submitter will again be notified of the problematic items. The submitter will be eligible to initiate a new review process for a second portfolio resubmission at least six (6) months after the failed resubmission review and following completion of an additional six (6) hours of consultation in the MAP System.

49. I heard that I cannot use the word “Psychoeducation” in documentation. However, these are the words used in Practitioner Guides. How should I describe these MAP sessions?

You can provide psychoeducation to youths and parents. For parents, make sure that you clearly demonstrate how the psychoeducation benefits the identified client and treatment goal(s).

50. Do PPMTs work on both Macs and PCs?

Yes, PPMTs can be used with both MAC and PCs if Excel is installed on the Mac or PC. (Note: Some macros on the PPMT may not be compatible with MACs.)

51. Is the Focus Interference Framework required documentation that must be present in my client's file? Must I do a FIF for every case?

No, the FIF is a process guide, not a required document. The FIF is intended to help develop a habit of mind and support integrative reasoning that should be applied to the analysis, understanding, and management of all MAP cases.

52. How can a therapist or supervisor make up missed consultation calls?

Additional consultation calls can be purchased through the www.practicewise.com website. The therapist or supervisor will need to log in to the site and click on the link titled "Subscribe." Under this link the individual may

choose to purchase additional MAP Direct Service or MAP Supervision consultation.

53. How can a therapist or supervisor make up missed consultation calls?

Additional consultation calls can be purchased through the www.practicewise.com website. The therapist or supervisor will need to log in to the site and click on the link titled "Subscribe." Under this link the individual may choose to purchase additional MAP Direct Service or MAP Supervision consultation.

54. How does a therapist or administrator obtain verification of completed consultation calls?

Verification of attendance on a consultation call series can be requested by emailing support@practicewise.com.

55. How will renewals of the group subscriptions be handled?

Subscriptions are renewed on a yearly basis. The contact person listed as the Group Administrator on the PracticeWise Group and Custom Order Form will receive the renewal reminder. Each individual user will NOT be contacted about the expiration date. The first renewal reminders were sent to all of the Group Administrators on October 31st, 2011. A second reminder will be sent on November 30th to any agency that has not already completed its renewal. The most common reasons for a failure to receive the renewal notice is an invalid email address or automated screening of the reminder email by the Group Administrator's email system. If you would like to verify the email address for your account, please contact support@practicewise.com to request information about the current Group Administrator record.

56. Are the subscriptions for the LAC DMH supervisor trainings separate from the original MAP Implementation subscriptions?

Yes, the supervisor subscriptions are established when the trainee attends a MAP Supervision and Consultation Series training event. As with the original subscriptions, the supervisor subscriptions are funded for the first year by LAC DMH. The renewals for the supervisor subscriptions will be sent out at least 30 days prior to the one year anniversary of the training dates.

57. Can I increase or reduce the number of subscriptions at the time of renewal?

Yes, an agency can increase or reduce the number of subscriptions it wishes to renew within the 30 days prior to the expiration. Any changes will be effective when the renewal is processed.

58. Can I get a list of the current users assigned to the group subscription?

Yes, please send your request to support@practicewise.com and you will receive the list of users and usernames currently assigned to the group subscription.

59. My agency has multiple subscriptions from different training cohorts. Can I consolidate them into a single group subscription for my agency?

Yes if the multiple subscriptions are funded directly an agency and not a third party payor such as LACDMH. A single consolidated subscription may be established and a prorated credit applied for the unused portions of the multiple separate subscriptions. Please send your request to support@practicewise.com.

60. How do I know if my portfolio submission has been received properly?

You will receive an e-mail to the address listed on the submission within two business days confirming the receipt of the portfolio and including a unique tracking number for the submission.

PARENT-CHILD INTERACTION THERAPY (PCIT)

1. What are the components of PCIT?

The model focuses on children who have externalized acting out behaviors. PCIT consists of two phases:

- 1) Focuses on enhancing the relationship through Child Directed Interaction (CDI).
- 2) Improves child compliance through Parent Directed Interactions (PDI).

Both phases of treatment include didactic training, followed by 7-10 coaching sessions. Therapist/coaches talk to parents via a communications system during the parent-child play sessions.

2. What is the age range for PCIT?

It is for children ages 2 to 7 and their caregivers within stressful and at-risk parent-child dyads.

3. What is the treatment modality for PCIT services?

The treatment modality is designed to have family sessions to improve interactions and the relationship between parent and child.

4. What is the length of treatment?

The average length of treatment is 16-18 sessions for 50 minute sessions once a week in the office. Treatment should be no more than 24 sessions.

5. Who can provide PCIT services?

Clinicians that have been approved by UC Davis training or appointed agency Trainer of Trainers (ToTs) are able to conduct treatment with Supervision until they have completed two cases.

6. Are there facility requirements to conduct PCIT treatment?

Appropriate space includes a stripped therapy room, a separate observation room with a one way mirror or video monitoring. Additionally, there must be a communication system that allows the therapist to speak in real time to the parent during parent-child interaction. Recommended age appropriate toys i.e. Potato heads, dolls houses, building blocks etc.

7. What are the outcome measures for PCIT services?

The PCIT model will use the following measures at the beginning, midpoint and end of treatment:

- 1) The ECBI/SESBI-R (Eyberg Child Behavior Inventory/Sutter–Eyberg Student Behaviors Inventory-Revised)
- 2) Y-OQ Youth Outcome Questionnaire

8. What kind of resources might we seek out to build our clinician's capacity to serve PCIT clients?

The guidelines can be found at <http://pcit.ucdavis.edu/>.

PROBLEM SOLVING THERAPY (PST)

1. What is PST and who may use it?

Problem Solving Therapy (PST) has been approved as a “promising practice” for older adult contract agencies providing PEI services. Problem Solving Therapy (PST) has been a primary strategy in such EBP’s as IMPACT/MHIP and PEARLS. PST has generally focused on the treatment of depression.

2. How is PST used in LA County DMH?

PST is to be used as an “early intervention” model intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally.

3. What is the target population?

Underserved Cultural/Ethnic Populations, Individuals with Early Signs of Mental Illness, Trauma – Exposed. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness (but who are not home-bound, isolated seniors for whom PEARLS would be the more appropriate treatment model.)

4. What are the goals of PST?

The goals of PST include: increasing the client’s understanding of the link between current symptoms and their current problems in living, increasing the client’s ability to clearly define their problems and set specific and measureable goals and finally to teach clients a specific structured problem-solving procedure that they can utilize throughout their lives.

5. Can PST be used with diverse cultural backgrounds?

This model is appropriate for both males and females and can be culturally and linguistically adapted to underserved cultural/ethnic populations.

6. What are the components of PST?

PST is a brief intervention model which involves 7 steps:

1. Clarify and define the problem
2. Set realistic goal
3. Generate multiple solutions
4. Evaluate and compare solutions
5. Select a feasible solution
6. Implement the solution
7. Evaluate the outcome

7. What are the minimum requirements for a practitioner to be able to provide PST?

Licensed and waived clinicians may offer PST consistent with their scope of practice.

8. What are the Core services and codes that are provided as part of PST?

- a. Assessment/Psychiatric Diagnostic Interview: 90791
- b. Individual Psychotherapy: H0046, 90832, 90834, 90837
- c. Targeted Case Management: T1017
- d. Individual Rehabilitation Services: H2015
- e. Team Plan Development: H0032

9. What is the length of treatment?

The number of sessions ranges from 6 – 10. The length of Initial session is 30-60 minutes; and should probably be guided by the client's capacity to actively engage in the various steps of PST. The frequency of sessions should also be guided by the urgency of the situation and the capacity of the client to have sufficient time and opportunity to implement each step of PST.

10. What is the timing of sessions?

Initial weekly sessions with increased time between sessions to bi-weekly sessions as client will have increased opportunities to practice skills. Initial session should last approximately 1 hour and the remaining sessions should last 30 minutes.

11. What outcome measures are used for PST for older adults?

The Outcome Questionnaire 45.2 (OQ) is the general measure used, and the Patient Health Questionnaire – 9 (PHQ-9) is the specific measure used. The OQ is designed to measure observed behavior change in a client from the beginning to the end of treatment. It should be administered at the beginning of treatment, possibly at the 6-month point, and at the end of treatment. The PHQ-9, the specific measure, should be administered every session to measure depressive symptom change throughout treatment. LAC DMH requires the use of the Outcome Questionnaire (OQ) and the PHQ-9 at the beginning of treatment to establish a baseline for all PEI programs for adults and older adults receiving PST. LAC DMH also requires that both of these measures be administered at the end of treatment to measure the effectiveness of treatment on symptom reduction and associated behavior change.

12. What is the training protocol?

Clinicians certified in PST, or trained in PEARLS, are qualified to implement this intervention model. PST Certification sessions are encouraged particularly when first learning this intervention model.

13. What is the setting where PST can be practiced?

PST services can be provided in any setting: outpatient clinics or field based.

14. Is there an adherence scale for PST?

Yes, there is a PST Therapist Adherence Scale called the PST Therapist Adherence Scale.

PROGRAM TO ENCOURAGE ACTIVE AND REWARDING LIVES FOR SENIORS (PEARLS)

- 4. What is the population to be served under PEARLS?**
PEARLS for Older Adults was designed to treat minor depression and dysthymic disorder in adults aged 55 and older.
- 5. What are the age range limits for implementing PEARLS under the PEI Plan?**
PEARLS is designed for adults aged 55 and older.
- 6. Are there exclusionary criteria?**
The PEARLS Program should not be used with clients who screen for Psychosis, Major Depression, Bi-polar Disorder, Alcohol or Substance Abuse or significant Cognitive Impairment.
- 7. What screening tools are required?**
Patient Health Questionnaire – 9 (PHQ-9)
Dysthymia Screening
Mini-Mental State Examination (MMSE) or Montreal Cognitive Assessment
- 8. What are the basic elements of the PEARLS Program?**
 - Focuses on teaching each client the skills necessary to move to action and make lasting life changes
 - It is delivered in the client's home
 - Takes a team-based approach, involving PEARLS counselors and supervisor or program manager
 - Aims to improve quality of life as well as reduce depressive symptoms, and
 - It is well-suited for individuals with chronic illness
- 9. What is the length of treatment?**
During six to eight in-home sessions that take place in the client's home and focus on brief behavioral techniques, PEARLS Program counselors empower individuals to take action and to make lasting changes so that they can lead more active and rewarding lives.
- 10. How often should PEARLS sessions be conducted?**
The PEARLS depression intervention is typically conducted over six to eight sessions in a six-month period and consists of problem solving treatment (PST), behavioral activation, and pleasant activities scheduling. During the course of the PEARLS treatment, the counselor must pay attention to different ways of conducting sessions depending whether it is a first, middle or last session. Throughout the period during which sessions are conducted, there is ongoing clinical supervision on a weekly or biweekly basis for the PEARLS counselor.
- 11. What are the required staffing patterns for PEARLS?**

PEARLS has identified four key roles: Manager, Supervisor, Counselor and Data Coordinator. (A single individual may serve in the role of Manager and Supervisor; but the PEARLS Counselor duties must remain clear and separate from the other roles.) In either case, it is important that everyone involved in the PEARLS Program work closely together.

12. What is the staff-to-client ratio?

PEARLS counselors can typically have a caseload of 20 clients, which includes a mix of clients having weekly, bi-weekly and month in-person session and client in follow up phone calls.

13. Where can PEARLS be implemented?

PEARLS was studied and proven to be effective as a home-based program. The developers of this model report there are some agencies who have modified it to be implemented as an agency-based program and have been very successful with it. While the developer cannot say that their research proves this is effective, there is some real-world evidence to encourage such an effort. Therefore, DMH will allow providers to implement PEARLS in other settings.

14. Please describe the training model for PEARLS:

After completing the two-day tailored PEARLS Training Program, participants will be able to:

- Identify depression using scientifically validated instruments
- Effectively assess depressed individuals and recommend steps to improve their mental health and overall quality of life
- Recognize the psychosocial needs and stressors particular to older adults
- Describe key elements of this comprehensive, multi-component depression management program
- Review the evidence base supporting the effectiveness of the PEARLS treatment program
- Demonstrate practical skills—such as problem-solving treatment, behavioral activation, and pleasant event scheduling—for treating depression in community-dwelling individuals
- Understand the key elements and personnel required to effectively implement PEARLS in their communities

15. Is there a Fidelity Scale for PEARLS?

There is a self-report questionnaire which may be used as a fidelity instrument called The University of Washington PEARLS FIDELITY INSTRUMENT that we have been granted permission to use and disseminate. Additionally, the toolkit does include an adherence scale which is a self-rating tool called The PST Therapist Adherence Scale.

16. Are Outcome Measures required and how often do they need to be completed?

Yes, outcome measures are required. The PHQ-9 is integral to the PEARLS model and used at beginning of treatment and re-administered at every session. Additionally, LAC DMH requires the use of the Outcome Questionnaire (OQ) and the PHQ-9 to at the beginning of treatment to establish a baseline for all PEI programs for adults and older adults receiving PEARLS. LAC DMH also requires that both of these measures be administered at the end of treatment to measure the effectiveness of treatment on symptom reduction and associated behavior change.

17. What are the CORE services and their codes that can be provided under PEARLS?

- Psychiatric Diagnostic Interview: 90791
- Individual Psychotherapy: H0046, 90832, 90834, 90837
- Targeted Case Management: T1017; (The client's assigned case manager may address the client's needs through targeted case management).
- Individual Rehabilitation Services: H2015
- Plan Development: H0032

18. What are the goals of PEARLS treatment?

The goals of PEARLS include: increasing the client's understanding of the link between current symptoms and their current problems in living, increase the client's ability to clearly define their problems and set specific and measureable goals and finally to teach clients a specific structured problem-solving procedure that they can utilize throughout their lives.

19. What are the components of PEARLS?

Three elements- Problem Solving Therapy, Behavioral Activation and Pleasurable Activity Scheduling

17. Please describe "Wrap-Up" Activities.

Following the last formal PEARLS sessions, the PEARLS counselor may provide periodic telephone "follow-up" calls for up to 60 days provided the following conditions are met:

- The follow-up phone calls are built into the treatment plan.
- There is discussion of skills used and what worked/didn't work.
- There is a clear plan, based on the of how the client will continue to use the skills
- There is some intervention to assist the client in continuing to use/start to use the skills learned. The conversation should involve an active role of the clinician.

PROLONGED EXPOSURE THERAPY FOR POST TRAUMATIC STRESS DISORDER (PE)

1. What is Prolonged Exposure for Post Traumatic Stress Disorder (PE)?

PE is an evidence based practice (EBP), which is theoretically based and a highly efficacious treatment for chronic post traumatic stress disorder (PTSD) and related depression, anxiety, and anger. Based on basic behavioral principles, it is empirically validated, with more than 20 years of research supporting its use. PE is a flexible therapy that can be modified to fit the needs of individual clients. It is specifically designed to help clients psychologically process traumatic events and reduce trauma-induced psychological disturbances. PE produces clinically significant improvement in about 80% of patients with chronic PTSD.

2. Who is appropriate for PE?

PE is intended for Adults (ages 26 to 59) and Older Adults (OA, ages 60+) in our Directly Operated programs. This EBP is appropriate for those who are experiencing symptoms of chronic PTSD resulting from one or more traumatic events including but not limited to the following: rape, physical assault, combat, community violence, motor vehicle accidents, natural disasters, and history of child abuse.

3. Does the client need to have a diagnosis of PTSD in order to receive this EBP?

Yes. The client must be diagnosed with chronic PTSD.

4. Who should not participate in PE Treatment?

PE is contraindicated for clients who are actively suicidal, homicidal, psychotic, experiencing a panic or anxiety attack, and/or at high risk of being assaulted.

5. What are the theoretical foundations of PE?

This EBP is based on the Emotional Processing Theory of PTSD. Specifically, traumatic memories must be activated in order to be processed on an emotional level while simultaneously correcting erroneous cognitions about the “world” and “self.”

6. What are the key components of PE?

PE is divided into the following four components: 1) Exposure Therapy, 2) Anxiety Management, 3) Psychoeducation, and 4) Cognitive Therapy.

- (a) Exposure Therapy: a set of imaginal and in-vivo exposure techniques designed to reduce pathological, dysfunctional anxiety, and erroneous cognitions by encouraging the client to repeatedly confront trauma-related objects, situations, memories, and images which have been avoided in the past.

- (b) Anxiety Management: relaxation training, breathing techniques, positive self-talk, positive visualizing, social skills, and distraction techniques.
- (c) Psychoeducation: educating the client about common reactions to trauma.
- (d) Cognitive Therapy: identifying, challenging, and replacing dysfunctional thoughts and beliefs with positive ones.

7. What is imaginal exposure?

Imaginal exposure is repeated recollection of a traumatic event. Confrontation with traumatic memories enhances the processing of these events and modifies dysfunctional cognitions, such as “I cannot tolerate distress” or “What happened is my fault.” This consists of asking the client to recall every detail, including events, thoughts, and feelings, of a troubling traumatic experience in the present tense.

8. What is in vivo exposure?

In vivo exposure is repeatedly approaching trauma-related situations that have been avoided because of their association with a traumatic event. It is very effective in reducing excessive fear and unnecessary avoidance. It enables the client to realize that the avoided situations are not dangerous, thus modifying dysfunctional cognitions that the world is a dangerous place. This is accomplished by asking the client to gradually increase their physical participation in activities and situations, via a hierarchy from the least to the most anxiety provoking, that have been avoided since the traumatic event occurred.

9. What are the treatment goals?

There are five main treatment goals for PE.

- (a) Decrease avoidance of trauma-related situations (e.g., sleeping without a light or refusing to go out alone).
- (b) Decrease avoidance of trauma-related thoughts and images.
- (c) Decrease presence of dysfunctional cognitions: “The world is extremely dangerous” or “I am extremely incompetent.”
- (d) Increase ability to discuss thoughts and feelings related to the traumatic event.
- (e) Increase engagement in activities related to the traumatic event.

10. What are the core interventions of PE?

The core interventions for PE are:

- Assessment (Procedural Codes 90801 and 90802)
- Individual Psychotherapy (Procedure Codes H0046, 90804, 90806, 90808)

Other interventions which may be appropriate during the course of the 10 individual psychotherapy sessions and may include:

-Targeted Case Management (Procedure Code T1017)

The use of targeted case management may be appropriate if providing these services will assist in the reduction of the effects of the traumatic event.

11. What is the length of treatment?

PE treatment consists of 10 weekly, consecutive sessions. The individual sessions are 90 minutes in length.

12. How are the 10 sessions structured?

The 10 sessions are divided into four distinct segments.

- (a) Introduction of the treatment program, in vivo hierarchy/exposure, and breathing training (Sessions 1-2).
- (b) Introduce and conduct imaginal exposure (Sessions 3-5).
- (c) Focus on “hot spots” (most distressing aspects of the recollected traumatic event; Sessions 6-9)
- (d) Final imaginal exposure (Session 10)

13. Are more than 10 sessions allowed by the model?

Yes. If clinically indicated, additional sessions, up to 8, are allowed for additional processing of the imaginal exposures.

14. What happens if the client misses a session?

Therapeutic progress may be lost if a client misses more than 2 consecutive sessions. This may be due to the client reinforcing the negative aspects of the trauma rather than using the tools necessary to overcome the traumatic event.

15. Can this model be used in a group setting?

No. PE was developed and designed for individual use only. Multiple clients going through in vivo exposure techniques and revisiting traumatic memories simultaneously in a group setting would be counterproductive.

16. What happens if a client continues to experience disruption in their level of functioning?

The client may need to continue with additional PE treatment, be hospitalized, and/or obtain additional mental health services. It should be noted that each case is unique and each client must be treated on a case by case basis.

17. Who can provide this EBP?

At this time the developer only allows clinicians (Masters level and higher, registered/waived and higher level clinicians) to be the primary leads in treatment. Paraprofessional staff can provide support with check-ins and case management.

18. What role can a psychiatrist and medication play with this practice?

Generally in this model, clients are not seen for a medication evaluation by a psychiatrist. On the other hand, there may be certain circumstances where a clinician may determine referring a client for a medication evaluation is appropriate. In these cases, not providing such services may be more harmful to the client's well being and may prevent the client from returning to their previous level of functioning, especially when additional symptoms are resulting in severe impairments.

19. Can a client from one of the Mental Health Service Act's (MHSA) Client Supportive Services (CSS) programs (Wellness, Field Capable Clinical Services, or Full Service Partnerships) or non-MHSA programs receive this EBP?

Yes. Any client receiving services in one of our MHSA CSS or non-MHSA programs can receive this and any EBP. The service will be claimed to the current MHSA plan in which the client primarily receives his/her services, NOT to PEI.

20. Can the client receive PE along with other EBPs?

Clients can receive 2 EBPs or Community Defined Evidence Practices simultaneously only when clinically indicated. However, the use of multiple EBPs for PEI clients should happen very infrequently.

21. What is the required training protocol?

Training consists of a 4-day workshop followed by weekly consultation and supervision of 2 active clients in regular treatment with client consent. Weekly consultation is conducted via review of audio-taped therapy sessions, which are be encrypted via electronic voice recorders, with certified PE Supervisors. Consultation will continue during the duration of active treatment for 2 clients.

22. Is "train the trainer" an option with this EBP?

No. The Department does not currently provide "train the trainer" as an option.

24. What are the outcome measures for PE?

There are two outcome measures which are required for PE:

- Post Traumatic Stress Diagnostic Scale (PDS) for ages 18-65
- Outcome Questionnaire (OQ) for ages 18+

25. Can the clinician claim for completing the outcome measure?

No. Administering an outcome measure is not a claimable service. There are two exceptions: (1) if the primary clinician closes the case as a result of referring the client to another agency, and at discharge, completes the outcome measure; or (2) if the outcome measure is completed during a billable session, and not over the phone or at home by the client.

SEEKING SAFETY (SS)

1. What is the population to be served under PEI?

Directed toward individuals and families for whom a short duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.

2. What are the age range limits for implementing Seeking Safety under the PEI Plan?

The age range begins at 13 years old and spans across all age groups.

- Children (13-15)
- Transition-Age Youth (16-25)
- Adults (26-59)
- Older Adults (60+)

3. What are the “Core Interventions” for Seeking Safety”?

The “Core Interventions” are:

- Assessment
- Individual and Group Psychotherapy
- Individual and Group Rehabilitation
- Family Psychotherapy
- Targeted Case Management

4. What is the length of treatment?

Length of treatment depends on how many topics are covered, the number of sessions conducted to complete a topic, and the frequency of sessions. On average, length of treatment will vary from 5 to 6 months.

5. How often should SS sessions be conducted?

SS sessions (individual or group) need to be conducted at minimum once per week to adhere to fidelity of the model.

6. Is there a maximum number of sessions and who monitors?

On average, each topic is conducted in 1 to 2 sessions. Therefore, if all 25 topics are conducted, number of sessions may range from 25 to 50.

It is recommended each provider monitors and tracks internal activities. Countywide and Service Area Administration will work collaboratively to monitor Seeking Safety services.

7. Does Seeking Safety have mandatory topics?

Yes. “Introduction to Treatment/Case Management” and “Safety” to be covered first to provide a foundation. “Termination”, when possible, at conclusion of treatment.

- 8. How many topics are recommended for treatment? Is there a maximum or minimum?**
The more topics completed the better the outcomes. The developer reported a study consisting of a minimum of 6 sessions yielded positive outcomes.
- 9. With a minimum of two clinicians, approximately how many clients can be served (caseload)?**
Dr. Lisa Najavits (developer) does not indicate a minimum or maximum number of clients to be served per caseload.
- 10. What is the staff-to-client ratio?**
“Staff-to-client” ratio will vary depending on whether clients are seen in individual or group modality.
- 11. Since Seeking Safety does not explore past traumas, how recent must the traumatic event be?**
Past traumatic events can either be recent or in the distant past, single events or multiple events. Please refer to “Principles of Seeking Safety” in the SS Manual (pages 5 to 15) for more information.
- 12. Must my client have experienced trauma to qualify for SS?**
Yes. For the purposes of claiming to the PEI Plan the client must have experienced trauma.
- 13. Do participants of Seeking Safety need to have any symptoms of PTSD?**
Yes.
- 14. Are the diagnoses of PTSD and Substance Use required for the SS model?**
No. PTSD and Substance Use do not have to be the diagnoses in order to use the SS model, but please use your clinical judgment to decide if SS is an appropriate model for your client. As is always the case, in order to claim to Medi-Cal, your client must meet criteria for a Medi-Cal eligible diagnosis and the service provided must be claimable to Medi-Cal.
- 15. Is Seeking Safety considered a crisis intervention?**
No. It is a stabilization model.
- 16. Can a client do Seeking Safety and also attend AA or other substance abuse treatment?**
Yes. Part of treatment is to support and encourage clients to connect with resources in their community.
- 17. Since family sessions are a core service, what should the content of the family session be?**

Including family member(s) during session(s) is not limited to any specific topic(s).

18. Is there “train the trainer” model for SS?

No. Please see question below for internal agency training.

19. Can an “Adherence Rater” train new staff to SS instead of attending a developer approved training?

The primary role of an Adherence Rater is to rate only internal agency staffs’ adherence to SS sessions. The Adherence Rater may also orient only internal agency new staff to SS instead of attending a developer approved training. Dr. Najavits, SS Developer, prefers to use “orient” instead of “train” to avoid any misrepresentation since there isn’t “train the trainer model”. Please see SS Fidelity and Adherence Guidelines for specific requirements and limitations.

20. Does the Department expect that agencies providing Seeking Safety will have their staff complete the SS Adherence Rater and Supervisor Trainings?

At this time, we are recommending Seeking Safety providers participate in the “SS Fidelity and Adherence Guidelines”. This will allow for sustainability and adherence to fidelity of the model.

21. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs, YOQ-SRs, OQs)?

Administration can be completed by a trained non-clinical or clinical staff. Scoring and interpretation should be completed by a trained clinician who possesses a master’s degree or higher. Data entry can be completed by trained non-clinical staff.

22. Can we verbally translate an Outcome Measure from English to client’s language?

No, this would invalidate the outcome measure because the person translating may not translate items exactly as they are meant by the outcome measure’s author. If an outcome measure cannot be completed due to language difficulties and there is no authorized translation in their native language available, then the appropriate “Unable to Collect” reason code should be indicated in PEI OMA for that outcome measure.

23. How often do the required Outcome Measures need to be completed?

Clinicians have 14 days from the date of the First EBP Treatment Session to collect the “Pre” measures, and 14 days from the date of the Last EBP Treatment Session to collect the “Post” outcome measures. PEI outcome measures should also be administered every 6 months (an “Update”) to clients enrolled in an EBP that lasts 6 months or longer.

24. If I did not collect “pre” outcome measures then is it still required to collect “post” outcome measures?

Each required outcome measure must be acknowledged in PEI OMA in one of two ways:

- The outcome measure’s score(s) is entered into the appropriate field(s) or
- “Unable to Collect” reason code is selected and entered into the “Unable to Collect” field.

25. Does SS Supervisor have to be a Clinical Supervisor?

Yes. At minimum, each agency at the Legal Entity or Directly Operated Clinic level is required to designate a “PEI SS Supervisor”. “PEI SS Supervisor” is required to be a licensed mental health clinician, meets agency’s requirements to provide clinical supervision, and trained in SS.

Please note “PEI SS Supervisor” is different from “SS Supervisor” as outlined in the SS Fidelity and Adherence Guidelines.

26. Do you have to be a mental health clinician to implement SS?

SS can be implemented by clinicians and non-clinicians (case managers, substance abuse counselors, etc.) operating within their “scope of practice”.

27. What is the minimum amount of education required to be trained in and apply this evidenced based treatment, in order to stay within an appropriate “scope of practice”?

The services listed under Core Interventions for each evidenced based treatment will determine the rendering provider’s scope of practice. For example, if one of the core services is Assessment, an Authorized Mental Health Discipline (AMHD) must complete the Assessment. If the core service is Individual Rehabilitation (Rehab), anyone within their scope of practice can provide Rehab services.

As it relates to non-licensed staff (Medical Case Worker, Substance Abuse Counselor, and Community Worker) providing individual/group rehabilitation will be based on the supervisor’s discretion. This means that the supervisor has assessed the staff’s knowledge, experience, and reviewed staff’s documentation and decided that the staff is capable of providing and documenting Rehab services (with or without a co-signature).

28. Do non-clinicians (i.e. case managers, substance abuse counselors) need to be trained in Seeking Safety, if they are going to be providing services under Seeking Safety?

SS trained clinicians and non-clinicians are able to deliver SS services within their scope of practice; which means they are able to deliver the identified SS “core interventions” (as defined below) and claim to the PEI Plan. Staff not trained in the SS model, may only deliver “non-core interventions” (as defined below).

- “Core Interventions” are those services intrinsic to the delivery of expected outcomes for each of the PEI Programs.
- “Non-Core Interventions” are to be provided on a short-term basis to meet emergent client needs.

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

- 1. Does the model address client's somatic response to threats, as well as boundary description in traumatized children?**
Yes. It is worked through in therapy.
- 2. For TF-CBT, how long are the clinicians in training and participating in consultation calls?**
Approximately one year. There is a two-day initial training and a booster training 6 months after.
- 3. When are the measurement tools administered? Is there a pre-test measurement?**
Beginning (pre) and at the end of treatment (post.)
- 4. Is DMH PEI rolling out TF-CBT for ages 3-18?**
Yes.
- 5. If clients score in the sub-clinical range in the pre-test for the PTSD-RI are they still eligible to receive TF-CBT?***
Sub-clinical pre-test scores alone do not preclude a client from receiving TF-CBT. It is possible that clients and/or their families under report on a measure and therefore, as with any intake, clinicians must consider other information gathering practices in addition to the measure, such as the assessment, observations, reports from others, etc., in determining functional impairment and medical necessity of a client.
- 6. Can a behavior specialist provide individual rehabilitation as part of the non-core services for TF-CBT?***
Yes.